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Making the invisible visible: A grounded theory study of female adult trauma survivors reconstructing reality with supportive others

Anke Kossurok

A thesis submitted in fulfilment of requirements for the degree of Doctor of Philosophy

School of Health in Social Science
THE UNIVERSITY OF EDINBURGH

2017
Declaration

I hereby declare that this thesis is of my own composition, and that it contains no material previously submitted for the award of any other degree. The work reported in this thesis has been executed by myself, except where due acknowledgement is made in the text.

Anke Kossurok
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Abstract

Violence against women and children is a pervasive challenge across the globe. Research has shown that survivors of interpersonal violence, such as child maltreatment and intimate partner violence, may develop a complex form of post-traumatic stress disorder accompanied by, for example, difficulties in regulating emotions and relating to others. Additional mental health and social problems contribute to survivors’ long-term impairment. Therefore, it is imperative that we understand the key elements and processes that facilitate trauma recovery. The majority of research places survivors as individuals at the core of understanding trauma and recovery, which makes it an intrapsychic problem focused on, for example, the individual’s cognitive bias, maladaptive interpersonal behaviour, or emotion dysregulation which need repairing, rather than considering appropriately the role of context, external factors and social processes. Thus, trauma recovery may be more complicated.

The current study explored key elements and processes of trauma recovery in female adult survivors with a focus on emotional and interpersonal skills, within the narratives of individuals constructing their own recovery within an interpersonal context. Fifteen female adult survivors were recruited from a statutory clinical service and a third-sector community project. Participants were interviewed individually, and data were analysed qualitatively using grounded theory.

The study constructed a framework of four key components. Women survivors initially disengaged from feelings, other people and themselves (1), gradually made hidden experiences visible (2) and examined these (3), and eventually reconstructed their reality (4). Although not always a linear process, this framework revealed a...
transition from self-guided to supported self-management. Women survivors sought out relationships, were impacted by relationships, and these relationships changed the way survivors responded. Thus, female trauma survivors reconstructed abuse, trauma and identity through various supportive others. Similarly, female survivors reframed emotional and interpersonal difficulties and gradually managed these through relationships.

Future research as well as theories, practices and policies need to consider the multifaceted and relational nature of interpersonal trauma recovery. Guidelines and practices, for instance, could include community-focused strategies that provide a larger network of support to survivors and, thus, would offer multiple opportunities to experience positive interactions. Equally, mandatory training of health care staff about interpersonal violence and subsequent trauma as well as training in relating positively to survivors would make a real difference.
Women and children from around the world continue to suffer from violent attacks and abuse. Research has shown that children who are maltreated and women who have been abused by a partner, may develop a complex form of post-traumatic stress. This means that they may find it difficult to manage their emotions and relate to other people. Other mental health and social problems add to the long term damage these people may be living with. It is very important for us to understand more about what helps people recover well after such traumatic experiences. The research that has been done so far has looked mostly at the trauma survivors themselves and how these individual people have been affected. Research studies have looked at how people who have been abused think about the world and other people, how they make relationships and how they manage their feelings and emotions. The aim has been to see how people can be helped to cope better with these aspects of life. However, getting better after abuse or violent attacks is more complicated. It is not just to do with the person but is affected by what happened and when, where the person is now and the situation, society and culture they live in.

This research study looked in detail at the different ways in which women who are recovering from past abuse are adapting and coping. The focus was on how these women handled their emotions and how they related to others. Women told their own life stories and talked about how they tried to make sense of what happened to them. Fifteen adult women were recruited from a healthcare support service and a third-sector community project. The individual interviews were recorded and analysed using a qualitative research method called grounded theory.
The study allowed us to build up a picture of women’s experiences and journey to recovery. There were four stages. Women survivors cut themselves off from feelings, other people and themselves at first. Then they gradually shared hidden experiences with others. Next, they started to look at what happened to them, and eventually they began to see themselves and others in new ways. The journey was not always a direct one but these women were able to move from coping alone to managing life better by getting help from others (supported self-management). Good relationships were at the heart of this recovery process.

Future research as well as theories, support and care services and policies need to consider the many sided and relational nature of interpersonal trauma recovery. Guidelines and support services, for instance, could include ways to enable wider support in the community and neighbourhoods and, thus, would offer those recovering from trauma more opportunities for positive experiences with people close by. Equally, mandatory training of health care staff about maltreatment in the home and its consequence to people’s ill-health as well as training of staff in relating well and being there for abused women and children would make a real difference.
Chapter 1: Introduction

1.1. Introduction

The following work presents a qualitative enquiry into the key components and processes of trauma recovery of female adults who experienced interpersonal violence and subsequent trauma. The focus was on emotional and interpersonal functioning embedded in this recovery journey. The method of grounded theory was employed.

This study was motivated by my interest in how people regulate emotions and relate to one another. I developed this interest during the final year of my undergraduate studies in psychology and deepened my understanding of it during a psychology master’s programme. During this time, I became fascinated with theoretical explanations of how feelings emerge and influence our thinking and behaviour, how thinking influences our appraisal of emotional states, and how we form meaningful relationships. I began to observe how people around me, and I myself, navigate through our emotional lives. For me, there is a fascinating interplay between feelings and interactions and how we manage these.

In further research, I wanted to bring theoretical understanding and real life experiences together, and explore these systematically in an applied setting. It was also important to me to address a problem that is relevant today and to people in the local community. My search led me, first, to a community project in Scotland that supported women with interpersonal trauma experiences and which fully acknowledged the relevance of managing attachments and emotions as part of the
recovery process. Secondly, I made contact with an NHS specialist trauma service. When familiarising myself with theoretical models of complex trauma, I learned that difficulties in regulating emotions and in relating to others are two of several key problems for trauma survivors and that a variety of treatment approaches have been developed to address these problems. However, it was unclear in the literature exactly how these treatment approaches facilitated the journey of recovery, and what the key elements of such treatments were that enabled people to change. I also began to question whether there are other key ingredients outside formal treatment that are crucial in the trauma recovery process. This question emerged, in particular, because the community project did not offer formal treatment, but there was something else going on that appeared to be important to trauma survivors.

Therefore, this research explored the overall process of how adults with a history of interpersonal trauma recovered, what the key elements of this recovery process were and, in particular, the process and key elements of gaining emotional and interpersonal competence within this overall journey.

1.2. Background and importance of this study

Understanding the consequences for survivors of violence against women and children has gained increasing interest among academics, policy makers, the media, and the public in recent years. Prevalence rates of interpersonal violence show that, globally, 8-31% of girls and 3-17% of boys experience child sexual abuse (Barth, Bermetz, Heim, Trelle, & Tonia, 2013), and 22.6% of children experience physical abuse, 36.3% emotional abuse, 16.3% physical neglect, and 18.4% emotional neglect (Stoltenborgh, Bakermans-Kranenburg, Alink, & van Ijzendoorn, 2015). Worldwide, 30% of women have experienced violence by an intimate partner, and 7.2% sexual violence by someone other than a partner (WHO, 2013). Research also found that girls and women are considerably more frequently exposed to traumatic events of
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Chapter 1: Introduction

An interpersonal nature than are boys and men (Barth et al., 2013; Benjet et al., 2016; Denholm, Power, Thomas, & Li, 2013; Finkelhor, Shattuck, Turner, & Hamby, 2014; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995; May-Chahal & Cawson, 2005; Pereda, Guilera, Forns, & Gómez-Benito, 2009a; Radford, Corral, Bradley, & Fisher, 2013; Stöckl et al., 2013; Stoltenborgh, van Ijzendoorn, Euser, & Bakermans-Kranenburg, 2011; UK Office for National Statistics, 2016b). This suggests that violence against women and children is a widespread pressing, global and persistent problem. The positive side is that these may be declining prevalence figures. Based on reports by Finkelhor and Jones (2006, 2012) and Jones and Finkelhor (2003), child protection cases have declined substantially between 1990 and 2010, and the authors suggested that this may be due to policy changes in the 1980s.

Violence against women and children leads to multiple, complex health consequences for trauma and abuse survivors. While the risk of developing post-traumatic stress responses after any traumatic event is on average 8% for men and women, the risk rises sharply for women exposed to interpersonal trauma events: for example, a 45.9% risk of PTSD (post-traumatic stress disorder) after experiencing rape, a 26.5% risk of PTSD after molestation, and a 48.5% risk of PTSD after physical abuse (Kessler et al., 1995). These figures were based on patients’ disclosure of trauma-related symptoms and past traumatic events as well as on the clinician’s skills in recognising trauma and diagnosing it accordingly. Thus, underreporting is likely. In addition, trauma survivors of abuse, particularly where that abuse was ongoing and/or experienced in childhood, showed more severe and complex trauma reactions beyond typical PTSD symptoms, such as emotion regulation difficulties, disturbances in relational capacities, alterations in attention and consciousness, adversely affected belief systems, and somatic distress or disorganisation (Cloitre et al., 2009; Cloitre, Miranda, Stovall-McClough, & Han, 2005; Courtois, 2004; Ford, Courtois, Steele, van der Hart, & Nijenhuis, 2005; Godbout et al., 2017; Godbout, Runtz, MacIntosh, & Briere, 2013; Jennissen, Holl, Mai, Wolff, & Barnow, 2016; Séguin-Lemire, Hébert, Cossette, & Langevin, 2017; Seligowski, Lee, Bardeen, &
Orcutt, 2015; van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). What is more, exposure to abuse increased the risk of developing other psychiatric disorders, such as substance dependency (Ullman, Relyea, Peter-Hagene, & Vasquez, 2013), depression (Jonas et al., 2011; WHO, 2013), dissociation (Zucker, Spinazzola, Blaustein, & van der Kolk, 2006), eating disorders (Mitchell, Mazzeo, Schlesinger, Brewerton, & Smith, 2012), self-harm (Martin et al., 2016), actual and attempted suicide (Castellvi et al., 2017; Seedat, Stein, & Forde, 2005), and personality changes (Resick et al., 2012). Poor physical health (e.g., heart and lung disease, stroke, diabetes, and hepatitis) and poor physical health behaviour (e.g., obesity, physical inactivity, and smoking) after child maltreatment have also been reported (Felitti et al., 1998; Jackson et al., 2016). Though, there may be differences in response depending on the type of childhood trauma (Jackson et al., 2016).

It is not surprising that this complexity of health difficulties impacts on survivors’ social circumstances resulting in poorer educational performance and work opportunities, higher unemployment, marital instability and parenting difficulties (Bigras, Godbout, Hébert, Runtz, & Daspe, 2015; Maguire et al., 2015; Perfect, Turley, Carlson, Yohanna, & Pfenninger Saint Gilles, 2016; Showalter, 2016; Vaillancourt, Pawlby, & Fearon, 2017). These factors ultimately also affect society as a whole and generate enormous economic and social costs. Fang, Brown, Florence, and Mercy (2012) estimated a lifetime cost per victim of child maltreatment of $585 billion in the US in 2010; Saied-Tessier (2014) estimated economic costs of child sexual abuse alone at £1.6 billion in 2012 in the UK. In comparison to other health problems, Waechter and Ma (2015) found that, in the US, abuse (predominantly experienced by women) generated economic costs that were almost twice than that of cardiovascular disease, almost four times than that of cancer or diabetes, and close to 20 times than that of HIV/AIDS – although in comparison, funding for prevention, treatment and research of abuse or trauma was tiny.
From a theoretical perspective, the concepts of attachment and resilience may explain underlying mechanisms of developing post-traumatic stress. Attachment postulates that humans have an innate system for survival which is activated when exposed to danger, threat or novelty, prompting them to seek comfort and safety from others, and it is deactivated when danger is no longer perceived (Bowlby, 1969/1982). Interpersonal violence is understood to disrupt secure attachment patterns which results in anxious or avoidant strategies when relating to others and a lack of capacity to self-regulate emotions, among other difficulties. There is strong evidence that insecure attachment in childhood is associated with child maltreatment and PTSD (e.g., Jardin, Venta, Newlin, Ibarra, & Sharp, 2017; Ogle, Rubin, & Siegler, 2015) as well as with emotional and social impairments (e.g., Cunningham & Baker, 2004; Lundy & Grossman, 2005), and that insecure attachment in adulthood is associated with trauma symptoms and sexual revictimisation (e.g., Brenner & Ben-Amitay, 2015; Woodhouse, Ayers, & Field, 2015). Nonetheless, there are some conflicting findings and these indicate that attachment may only explain parts of the underlying processes. In particular, it tends to focus on the individual’s attachment style rather than on the dyadic attachment dynamic.

Alternatively, the concept of resilience has been used to explain the difficulties of coping after interpersonal trauma. One definition of resilience has been defined as the ability to continue developing normally despite difficult circumstances. Normal functioning is attributed to a combination of protective factors, while abnormal functioning is attributed to a combination of risk factors. In this respect, a lack of resilience after interpersonal trauma has been associated, for example, with negative trauma appraisal (Barlow, Goldsmith Turow, & Gerhart, 2017; Ehlers & Clark, 2000), high emotional reactivity (Badour, Resnick, & Kilpatrick, 2017), difficulties in managing strong feelings (e.g., Jennissen et al., 2016; Seligowski et al., 2015), problems in relating to others (e.g., Charuvastra & Cloitre, 2008), and a lack of positive social support (Ozer, Best, Lipsey, & Weiss, 2003). While ‘resilience’
encompasses wider aspects than ‘attachment’ (including external factors), the problem is that this focus places the individual survivor at the centre of understanding trauma and recovery while the role of environmental and social process may not be fully recognised. It is this somewhat narrow view that formed a particular area of interest to be explored within this study.

Conventional treatment approaches, such as cognitive-behavioural therapy (CBT), aim to reduce classical PTSD symptoms (e.g., Cloitre et al., 2010, 2011; Ehring et al., 2014; Krupnick et al., 2008) but be less effective in addressing interpersonal and emotion regulation difficulties (Bryant, 2010; Cloitre et al., 2010; Markowitz, Milrod, Bleiberg, & Marshall, 2009). By contrast, treatment that first seeks to establish emotional and social safety through psycho-education has been more successful (Cloitre et al., 2010; Cloitre, Koenen, Cohen, & Han, 2002; Herman, 1992; Karatzias, Ferguson, Gullone, & Cosgrove, 2016). However, from this typically quantitative research (which tended to rely on cross-sectional designs and retrospective self-reports) little is known about the mechanisms and active ingredients of recovery from interpersonal trauma, not to mention the mechanisms and key elements for gaining emotion regulation and interpersonal skills. Qualitative research has investigated trauma recovery more broadly (i.e., beyond formal treatment) (e.g., Banyard & Williams, 2007; Chouliara, Karatzias, & Gullone, 2014); but while providing in-depth answers to recovery overall, these studies have not explained the processes and key elements involved in improving core aspects of interpersonal trauma, namely emotion regulation and interpersonal difficulties.

1.3. About this study

The purpose of this study was to advance our understanding of how female adult trauma survivors cope after experiencing interpersonal violence and subsequent trauma. In particular, this study aimed to investigate the key mechanisms that
assisted them in gaining skills in emotion regulation and interpersonal functioning. In order to explore this topic, women trauma survivors were interviewed individually about experiences that they considered important to their recovery from trauma. It was crucial to hear perspectives directly from those people whose experiences were the focus of the research, and who might ultimately benefit from this work. The study took place in Central Scotland and recruited survivors from a local community project supporting traumatised women, and from an NHS specialist trauma clinic. These distinctly different sites were chosen to allow diverse responses to emerge in relation to what matters to people who recover from abuse and trauma. Women were known community members (community site) or had attended formal treatment (clinical site); occasionally they attended both services. A grounded theory approach was employed for data generation and analysis. Therefore, this research attempted to generate a theory based on the research questions.

### 1.4. Terms explained

Several terms require clarification as to how they will be used in this thesis. The term ‘trauma’ can be ambiguous and taken to mean the trauma incident (i.e., the abuse), the subsequent trauma symptoms, or both. Here, using only the word ‘trauma’ will be avoided. Instead, trauma/traumatic incident or event, abuse, adverse or traumatic experience, and maltreatment will be used to refer to the abusive event. Trauma symptoms, day-to-day difficulties, trauma effects, trauma consequences or trauma sequelae will be used to refer to the negative impact on a person’s life following an abusive event.

The term ‘recovery’ will be used more loosely to begin with and then will be defined by participants in this study. Alternative expressions used may be coping, healing, getting better, and improving.
Individuals who experienced abuse tend to identify themselves as a *victim* or as a *survivor*. It is acknowledged here that this is a personal choice. For this thesis, ‘victim’ will be used to refer to child victims of abuse and neglect, and ‘survivor’ or ‘trauma survivor’ will be used to refer to adults who were abused in childhood and/or adulthood (adopted from Children’s Commissioner (full) report (2015, p. 13)).

In order to distinguish the two research sites and their participants, the local non-statutory community project will be referred to as ‘community site’, and its participants as ‘community members’; and the NHS specialist trauma clinic will be referred to as ‘clinical site’ and its participants as ‘patients’. Where this distinction is not needed, the terms ‘research sites’ and ‘participants’ will be used.

1.5. **Structure of the thesis**

Chapter two will begin with a historical overview of interpersonal trauma and with a review of the literature. This narrative review will look at prevalence rates of violence and trauma and of different types of interpersonal trauma. A case will be made for why it is important to study interpersonal trauma, considering the costs to the individual survivor and to society. Subsequently, an overview of attachment, resilience, cognitive coping, emotion regulation and interpersonal difficulties will be presented. Then, various therapeutic approaches will be examined in terms of their effectiveness in treating these difficulties. Because this review is preparing for a qualitative study, previous qualitative research in this area will be explored in order to establish what published work has contributed to our current understanding of what ingredients and processes trauma treatment and trauma recovery require. This literature review will clarify the gaps in our knowledge, some of which in turn provide the basis for the research question and aims of the doctoral study.
In chapter three, the methodology and study procedures will be described. Beginning with ontological and epistemological questions, it will highlight the pros and cons of qualitative research and, particularly, grounded theory. This chapter will also show why these methods were a good choice for this study compared with alternative approaches. Then the setting, sample and data generation will be described, and the quality of this research will be addressed. This study involved interviewing trauma survivors about their recovery journey and, because this is regarded a sensitive topic, so how to conduct safe and ethical research is considered. A final section will describe how the data were analysed.

Chapter four will present the results beginning with a description of the participants, and then providing an overview of generated themes. Next, survivors’ difficulties will be reported before presenting the recovery strategies that they adopted by themselves in isolation and their recovery strategies they adopted together with others in treatment or people in their immediate surroundings. Then the ultimate aim of the recovery journey will be presented. While the developed, theoretical model focused on individual recovery, a wider aspect was uncovered that expanded the model to encompass a social dimension. This broader dimension was also found to be important in facilitating survivors’ recovery from trauma.

The final chapter (five) will summarise and discuss the research findings. This will not only show how these findings answered the research questions but also how the results related to issues raised in the initial literature review (Chapter 2). In this respect, implications for theory, practice and policy will be evaluated. Finally, study limitations, reflections, and future research will be discussed before highlighting the contribution of this academic work to our understanding of trauma and recovery.
Chapter 2: Literature review

2.1. Introduction

This literature review will systematically explore our current understanding of interpersonal trauma, related difficulties, underlying mechanisms, and treatment and identify important gaps and unanswered questions. Databases including PsycINFO, EMBASE, OvidMEDLINER, ASSIA, and Web of Science were searched. Key search terms included:

- trauma*, post-trauma*, posttrauma, PTS*, PTSD, DESNOS,
- child* abuse, child* maltreatment, child* neglect, child* sexual abuse, child* physical abuse, child* emotional abuse,
- domestic violence, intimate partner violence, IPV, sexual violence, sexual abuse, physical abuse, emotional abuse, partner abuse, rape, sexual assault.

Depending on the focus of each section in this chapter, these key terms were combined with the following search terms: historical perspective, prevalence, economic costs, addiction, depression, anxiety, eating disorder, schizophrenia, psychosis, self-harm, suicide, education, employment, attachment, resilience, post-traumatic growth, coping, reappraisal, emotion*, affective*, feel*, emotion* regulation, affect regulation, emotion* dysregulation, affect dysregulation, self-regulat*, self-control, emotion* control, interpersonal difficult*, interpersonal, relatedness, self-capacit*, intimacy, relationship conflict, communication, interaction, revictimisation, treatment and therapy. The majority of this search was restricted to academic literature published between 2015 and 2017, but where necessary this was broadened.
(e.g., historical perspective, prevalence). The search was also complemented by including key literature published before 2015.

The review will consider the historical perspective of our understanding of interpersonal trauma. This will help to place more recent research in a wider perspective before focusing more specifically on recent prevalence rates of child and adult abuse and of trauma effects, on definitions of different types of abuse, on costs to mental health, physical health and social functioning of the individual and the economic cost to society. Then, an overview of attachment theory will be given showing how disrupted attachment patterns contribute to mental health issues following interpersonal violence. Because attachment may not fully explain the underlying processes, resilience will be discussed as an alternative concept. Risk factors that threaten resilience in relation to trauma will be discussed with reference to cognitive, emotional and interpersonal difficulties. Then, various therapeutic approaches and informal interventions will be examined in terms of their effectiveness in addressing these difficulties. This literature review will conclude by summarising the gaps in our knowledge of trauma and recovery, some of which will provide the basis for the research questions and aims of my study.

2.2. **Historical review of abuse and interpersonal trauma**

The concept of ‘interpersonal trauma’ is relatively new, and so are the systematic investigations that have increasingly been reported in this field. Before beginning to look at current understandings, it is important to be familiar with the historical development of how interpersonal trauma has been understood in the past. This will help set the presented review and my study in a wider context. The literature review will focus on Western perspectives relevant to the current study.
2.2.1. Early attempts to evidence abuse of women and children

Accounts of psychological trauma have been recorded in historical, literary and medical writing since, at least, the third century BC (Birmes, Hatton, Brunet, & Schmitt, 2003; Knight, 1986; Lynch, 1985) or in some cases since around 2000 BC (Kucmin, Kucmin, Nogalski, Sojczuk, & Jojczuk, 2016). Lynch (1985) showed that some of these documents indicated awareness of children being neglected, battered or killed by parental figures. However, more systematic and scientific investigations into traumas of interpersonal nature have only begun since the late 19th century. According to Knight (1986) and Lynch (1985), these investigations focused on physical injuries to children – such as fractures, suffocations, deprivation, and head injuries – and their origins were explained away as disease-related or accidents. One of the first to evidence a link between these injuries and child maltreatment inflicted intentionally by adults was Ambrois Tardieu, a French forensic physician (Knight, 1986; Labbé, 2005; Lynch, 1985). Tardieu also investigated several hundred cases of sexual abuse in both children and adults, and males and females; and he attempted to persuade physicians of the physical and psychological consequences of such abuse on individuals (Labbé, 2005). However, he was ignored by the medical community and his appeal to support survivors of abuse was disregarded (Knight, 1986; Labbé, 2005; Lynch, 1985). Instead, Knight (1986) and Labbé (2005) suggested that maltreatment of children continued to be understood as a parental obligation to discipline the child or as curing diseases of the child. Maltreatment of children by parents was also known in England where the English Society for the Prevention of Cruelty to Children (in 1883), and the London Society (in 1884) were established to take such cases to court (Lynch, 1985).

With regards to sexual abuse and rape of women, Bourke (2012, p. 29) proposed that women were viewed as imposters when accusing a man of rape and that “hysteria [was considered] as a condition that resulted in false accusations of rape, rather than being caused by rape”. In other words, for women to speak of rape was problematic
because it was seen as challenging the social and economic positions of the accused and affecting the family and friends of the victim, and not because it was harming the psychological well-being of the abused woman.

2.2.2. Attempts to document neurological symptoms of hysteria

The term hysteria was common and widely used in the 19th century, especially for women, but had not been systematically investigated (Herman, 2015). In the late 19th century, Chacot, a French neurologist, examined hysterical patients of Salpêtrière, a Parisian asylum (Herman, 2015; Weisæth, 2002). He observed these patients, documented their symptoms, and displayed these patients and their symptoms in public demonstrations. While he focused on highlighting neurological injuries associated with the signs of hysteria, such as convulsions, and impairment of movement, sensory functions and memory, he neglected to consider psychological symptoms, the person’s internal experience, and psychological or social causes underlying hysteria (Herman, 2015).

2.2.3. Early psychological enquiries about women’s hysteria

Three of Chacot’s students – Janet, Breuer, and Freud – investigated why these symptoms might emerge. According to Herman (2015), Janet, Breuer, and Freud conducted meetings that were often hour-long and daily with their female patients in which both doctor and patient collaboratively investigated the origins of the hysterical symptoms. In this ‘talking cure’, they meticulously reconstructed memories of patients’ pasts. This was remarkable at the time because “for a brief decade men of science listened to women with a devotion and a respect unparalleled before or since” (Herman, 2015, pp. 11–12). In the 1890s, all three decided on the same formulation, namely that psychological trauma is the cause of hysterical symptoms.
and that memories of traumatic incidents surfaced in other forms, such as memory difficulties, dissociation, seizures, frozenness, or emotional outbreaks – known as hysteric symptoms (Herman, 2015). Yet, most of them did not investigate systematically the type of trauma experiences that might be associated with hysteria.

### 2.2.4. Evidence and doubts about links between child sexual abuse and hysteria

Freud, and to a smaller extent Breuer, made further enquiries and discovered that hysteric patients talked of incest, sexual attacks and abuse (Breuer & Freud, 1895; Freud, 1896; Herman, 2015). Freud reported his findings in his work *The Aetiology of Hysteria* in 1896 and suggested that: “at the bottom of every case of hysteria there are *one or more occurrences of premature sexual experience*, occurrences which belong to the earliest years of childhood, but which can be reproduced through the work of psycho-analysis in spite of the intervening decades. I believe this is an important finding ...” (Freud, 1896; translated version in Herman, 2015, p. 13).

Yet again this paper was largely disregarded by the scientific community. Robinson (1993) proposed that the sceptics doubted the widespread occurrence of abuse and trauma in Freud’s patient sample and disputed the validity of Freud’s psychoanalytic procedure. A year later, Freud himself rejected his postulated ‘seduction theory’ in a letter to Wilhelm Fliess (21.09.1897) stating four reasons: (1) patient drop-outs and a lack of treatment success, (2) a disbelief that these “perverted acts against children [in particular by the father or uncle] were so general”, (3) uncertainty over whether what the unconscious reveals is “truth or emotionally-charged fiction” and (4) the impossibility of treating this neurosis because the conscious appeared to dominate the unconscious, earliest infantile experiences making these experiences inaccessible to treatment (Bonaparte et al., 1954, pp. 215–216; addition in square brackets from Rush, 1996, p. 264). One might conclude from these four arguments that the initial theory
was dismissed because the problem (i.e., abuse and trauma) was too difficult to treat or accept as true. Alternative arguments, such as the theory being plausible, were not pursued because Freud lacked the necessary therapeutic skills and scientific knowledge. Despite the claimed importance of his thesis in 1896, he later expressed his opinion to Fliess that he felt “not in the least disgraced” and had “a feeling more of triumph than of defeat” (Bonaparte et al., 1954, p. 217).

Subsequently, Freud put forward a radical change of direction in his theory. Instead of arguing that adults seduced innocent children into having premature sexual encounters, he suggested that it was the child, and particularly the female child, who had early innate desires to seduce, or be seduced by adults (Herman, 2015). This shift gave rise to believe in a theory that was regarded as more acceptable because it constructed hysteria as an internal problem residing with the (usually female) patient and not as an external problem caused by people (usually male family members) around the patient. Throughout the late 19th and early 20th century, ‘emotional shock’, suddenly developed ‘fright’, panic attacks and other psychiatric conditions in children were recorded, but the link to child abuse, particularly sexual abuse, was dismissed (Bourke, 2012). Thus, childhood sexual abuse continued to be ignored as a common social problem (Rush, 1996). However, reviewing historical perspectives on abuse related trauma theory has revealed inherent tensions between scientific investigation and the traditional social values of the time. A growing awareness of this dichotomy may have signalled the beginning of a cultural shift in the field of abuse and trauma.

2.2.5. Growing momentum in recognitions of child maltreatment and subsequent trauma

By the mid-20th century, researchers were increasingly investigating physical injuries in children and they concluded that mistreatment by parents or close
relatives was a common cause. Lynch (1985) cited several examples from the 1950s where physicians advocated for childhood physical abuse to be more widely recognised and for measures to be taken to prevent corporal punishment within the family. A significant milestone was the Kempe, Silverman, Steele, Droegenmueller and Silver’s (1962) paper on the battered-child syndrome. This paper referred not only to physical abuse as trauma but connected physical abuse to psychiatric problems. With regards to the latter, Kempe and colleagues acknowledged that few (if any) systematic investigations existed, but that emotional and social difficulties could be observed as psychological effects on the child. He also appealed to physicians in that they have: “a duty and responsibility to the child to require a full evaluation of the problem and to guarantee that no expected repetition of trauma will be permitted to occur” (Kempe et al., 1962, p. 3288).

2.2.6. The women’s movement prompts a wave of research into violence against women

While investigations on the physical and psychological consequences of childhood abuse continued, investigations into the physical and psychological consequences of violence against women remained a peripheral issue until the women’s movement of the 1970s emerged (Herman, 2015). According to Bourke (2012), only 33 of 381,000 papers published in medical journals in the 1950s and 1960s reported on rape, and intervention programmes were largely unavailable. She also suggested that rape was understood as a consequence of women becoming ‘insensible’. That is, it was assumed that the women had become frightened and had lost possession of themselves first, and that this then allowed the sexual assault to happen (Bourke, 2012). With regards to domestic and intimate partner violence, punishing his wife was understood either as a minor offence or as a husband’s right until the 1960s (US) (Barner & Carney, 2011).
However, in the 1970s several important events occurred: Firstly, women began to speak out about rape and sexual assault and to break down “barriers of denial, secrecy, and shame” (Herman, 2015, p. 29). Secondly, doctors and other health professionals acknowledged the psychological suffering and subsequent need for support of rape victims – though they were not equipped to address this need (Bourke, 2012). Thirdly, women academics began to research their own life using scientific methods, and this resulted in an explosion of research on rape and the victimisation of women (Barner & Carney, 2011; Bourke, 2012; Herman, 2015). Subsequently, victimisation of women and its traumatic effects entered mainstream understanding. Systematic investigations increased; support centres for women were established; changes to legislations were made (Barner & Carney, 2011; Bourke, 2012; Herman, 2015). These changes challenged the previously widely held belief that women apparently allowed rape and domestic violence to happen. Instead, victimisation against women became reconstructed by the feminist movement as “a method of political control, enforcing the subordination of women through terror” (Herman, 2015, p. 30).

### 2.2.7. Post-traumatic stress is recognised as a formal diagnosis

In 1980, the psychological difficulties resulting from traumatic events were added as Post-traumatic Stress Disorder (PTSD) to the diagnostic manual (Lasiuk & Hegadoren, 2006). This development was a result of decades-long discussions about whether war veterans’ suffering was legitimate or imagined (Herman, 2015; Weisæth, 2002). This was an important milestone because it recognised trauma survivors’ suffering as genuine. However, this diagnosis did not appear to encapsulate women’s suffering after traumatic events, such as rape, in the same way and their experiences continued to be questioned critically from a diagnostic perspective (Bourke, 2012; Herman, 2015).
Even today, alternative diagnoses (e.g., Disorders of Extreme Stress Not Otherwise Specified (DESNOS) and complex PTSD) describing women’s psychological difficulties following victimisation are still widely debated (Bryant, 2010, 2012; Cloitre, Garvert, Brewin, Bryant, & Maercker, 2013; Hegadoren, Lasiuk, & Coupland, 2006; Herman, 1992; Resick et al., 2012; Scoboria, Ford, Lin, & Frisman, 2008; van der Kolk et al., 2005). Similarly, abuse of women and children has not been eradicated despite the major expansion of research since the 1970s. Rather, research is still in the early stages of uncovering the huge extent of abuse worldwide, the different types of abuse, the multiple detrimental effects on individuals’ health, and the potential treatments. Such developments include, for example, extending the definition of abuse to include neglect and emotional abuse, as well as male victims. Numerous initiatives have emerged to support abuse survivors (irrespective of gender, age, ethnicity etc.). However, their work is repeatedly undermined by struggles for funding (e.g., Barner & Carney, 2011; Waechter & Ma, 2015), and there continues to be a debate over who to believe: the abused individual or the accused individual (Herman, 2015).

Violence against women and children – and therefore their psychological suffering – was conceptualised quite differently 100-150 years ago compared to our current understanding. Violence in today’s sense was not regarded as violence but was accepted as the right of an adult to discipline a child, and of the male to have control over the female. Consequently, children’s and women’s psychological suffering was ignored, actively denied or distorted. Considerable changes have been made in the way Western society thinks about interpersonal violence and trauma. However, abuse continues to exist on a large scale, as will be discussed in the next section. While it does, interpersonal trauma and suffering continues to be a current topic in research today. This historical review suggests that the previous hundred years may only be the early stages of a paradigm shift.
2.3. Prevalence rates of trauma and violence against women and children

For the current study, it is important to understand the extent of interpersonal violence and trauma today. Therefore, this section will provide an overview of the prevalence 1) of trauma overall – in order to compare the extent of interpersonal and non-interpersonal trauma experiences, 2) of interpersonal violence against children, 3) of interpersonal violence against women, and 4) of developing post-traumatic stress disorder. Most of the research presented here will focus on studies from the UK because the research for this thesis was conducted there. It will also focus on studies from the US because they are considered world leaders in this field and the US can be regarded as broadly similar to the UK with respect to economic and social life. In addition, the global extent of interpersonal violence and trauma will be explored. Figures will show a significant gender difference which has given rise in this research to a focus on female trauma survivors rather than on male trauma survivors. The author does not wish to negate the existence of interpersonal violence against men, of their suffering as a result of this, and the need to understand abuse and trauma recovery of men. There is increasing evidence of men’s experience of interpersonal trauma (Finkelhor et al., 2014; May-Chahal & Cawson, 2005; Radford et al., 2013; UK Office for National Statistics, 2016a, 2016b). There is also awareness that their experience is underreported (Easton, 2013). However, considering the current known prevalence rates worldwide, there is a greater need to advance trauma recovery in female survivors.

2.3.1. Prevalence of trauma event exposure

Several studies in the 1990s have investigated the extent to which individuals are exposed to traumatic events. Epidemiological data from US surveys revealed that about 50-90% of individuals experienced traumatic events in their lifetime (Breslau
et al., 1998; Kessler et al., 1995; Resnick, Kilpatrick, Dansky, Saunders, & Best, 1993). In 2016, a global epidemiological study reported that 70.4% of individuals (ranging from 28.6% to 84.6% across countries) experienced at least one traumatic event in their lifetime (Benjet et al., 2016). Resnick et al. (1993) reported 35.58% interpersonal and 33.3% non-interpersonal trauma exposure. This study investigated women only. By contrast, Breslau et al. (1998) included both men and women and showed that 37.7% of trauma experiences were of interpersonal and 59.8% of non-interpersonal nature. This study was limited to the population of Detroit in the US. A nationally representative study was undertaken by Kessler et al. (1995). Their research did not distinguish between interpersonal and non-interpersonal trauma as previous studies had, but between men and women’s exposure to different trauma types. The authors demonstrated that women were more exposed to events of rape (9.2% women, 0.7% men), molestation (12.3% women, 2.8% men), neglect (3.4% women, 2.1% men) and physical abuse (4.8% women, 3.2% men) than men. Men were more exposed to events of physical attack (11.1% men, 6.9% women), combat (6.4% men, 0.0% women), being threatened with a weapon (19.0% men, 6.8% women), accidents (25.0% men, 13.8% women), natural disasters (18.9% men, 15.2% women) and witnessing trauma (35.6% men, 14.5% women) than women.

2.3.2. Prevalence rates of interpersonal violence against children

In terms of adverse experiences in childhood, US research undertaken in 1995-1997 by the Centers for Disease Control and Prevention (2016, CDC-Kaiser ACE Study) reported that 28.3% of adults recalled having experienced physical abuse, 20.7% sexual abuse, 12.7% experienced their mother being treated violently, 14.8% emotional neglect, 9.9% physical neglect and 10.6% emotional abuse before the age of 18. A stark gender difference begins to surface when investigating these experiences in more detail: in most cases, more girls than boys are exposed to child maltreatment. For example, a recent study by Finkelhor et al. (2014) has found that 26.6% of girls
compared to 5.1% of boys experienced sexual abuse or sexual assault by the age of 17 with girls experiencing an increase of almost 10% from age 15 (16.8%) to 17 (26.6%) and boys an increase of less than 1% from age 15 (4.3%) to 17 (5.1%). Compared to only 1.9% of boys, 11.2% of girls reported that an adult was the perpetrator.

In comparison, a UK study by May-Chahal and Cawson (2005) found that childhood maltreatment in a population of 18-24 year-olds comprised 7% physical abuse, 6% emotional abuse, 6% neglect, 5% absence of supervision and 11% sexual abuse. These rates are considerably lower than in the CDC-Kaiser ACE Study from the US. The gender difference was most striking for experiences of sexual abuse – 15% girls and 6% boys – and for emotional abuse – 8% girls and 4% boys. However, later UK studies revealed different prevalence rates. Denholm et al. (2013) followed a British birth cohort from 1958 up to age 45. Compared to May-Chahal and Cawson’s (2005) study, only 1.6% reported having experienced child sexual abuse (2.7% females, 0.5% males), 2.7% reported having experienced child neglect (3.5% females, 1.8% males), but 10% reported emotional abuse (11.7% females, 8.3% males). The lower numbers in this study compared to the 2005 study could be as a result of investigating different generations: The 1958 cohort may have understood early experiences of abuse or neglect as being disciplined by parents, instead of recognising and disclosing it as abuse or neglect – an hypothesis that has been suggested before by Hobbs (2005).

A third UK study, also of 18-24 year-olds, distinguished child sexual abuse by parents/guardians from that inflicted by other adults or peers (Radford et al., 2013). It found that only 0.6% of parents or guardians were perpetrators, while 24.1% of other adults or peers were the abusers. Again, there was a remarkable gender difference for sexual victimisation by adults or peers: 31% of young women but only 17.4% of young men were victims. Intimate partner violence was also reported, again with a strong gender difference of 16.2% females and 10.7% males. Another difference from the other two UK studies (i.e., Denholm et al., 2013; May-Chahal &
Cawson, 2005) was a higher rate of child neglect affecting 16% (with only a small gender difference). In 2016, the UK Office of National Statistics (2016a) published population-based survey results of child maltreatment in England and Wales. They showed that 9% (11% female, 7% male) of adults had experienced psychological abuse, 8% (10% female, 6% male) witnessed domestic violence, 7% (both male and female) experienced physical abuse, and 7% (11% female, 3% male) experienced sexual abuse in childhood. This study was noteworthy in that it included a large age range (16-59 years-old). For all three UK studies, reports of physical and emotional abuse ranged from 6.1%-8.4% to 6%-10%. Although, the gender difference was less striking, female participants consistently reported higher rates. Table 1 (p. 24) provides an overview of different prevalence rates of child maltreatment.

There is evidence that these rates may have declined in the last two decades. Based on reports by Finkelhor and Jones (2006, 2012) and Jones and Finkelhor (2003), child protection cases have substantially declined between 1990 and 2010 in the US and UK, and the authors suggested that this may be due to policy changes in the 1980s. In particular, child sexual abuse cases in the US decreased between 1992 and 1999 by 39% (Jones & Finkelhor, 2003) and child maltreatment between 1993 and 2004 by 40-70% (Finkelhor & Jones, 2006). Similarly in England (UK), cases of child physical and sexual abuse declined from 40% to 15% and from 26% to 6%, respectively; though an increase was observed for child neglect from 27% to 45% between 1994 and 2009 (Finkelhor & Jones, 2012). This evidence was based on administrative data which documented officially recorded cases. While self-report data (such as May-Chahal and Cawson (2005) and Radford et al. (2013)) would also capture cases that were not notified formally, the majority of the studies were limited to specific age groups making it difficult to draw inferences about changes in prevalence of abuse over time. An exception was the data from the UK Office of National Statistics (2016a) which found that younger adults reported less sexual assault than older adults. This observation may indicate a decline in child abuse in recent decades, though it could also be due to disclosure being more difficult for survivors in the early years after exposure to abuse.
Table 1

Differences in reported prevalence rates of child maltreatment in the UK

<table>
<thead>
<tr>
<th>Source</th>
<th>Sexual abuse</th>
<th>Physical abuse</th>
<th>Psychological abuse</th>
<th>Neglect</th>
<th>Intimate partner violence</th>
<th>Witnessing domestic violence</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F</td>
<td>M</td>
<td>F</td>
<td>M</td>
<td>F</td>
<td>M</td>
</tr>
<tr>
<td>Denholm et al. (2013)</td>
<td>16</td>
<td>27</td>
<td>6.1</td>
<td>6.0</td>
<td>10</td>
<td>8.3</td>
</tr>
<tr>
<td>May-Chal &amp; Cawson (2005)</td>
<td>1</td>
<td>15</td>
<td>6</td>
<td>8</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>Radford et al. (2013)</td>
<td>24.1</td>
<td>21.1</td>
<td>31</td>
<td>8.4</td>
<td>8.3</td>
<td>9.9</td>
</tr>
<tr>
<td>UK Office of National Statistics (2016a)</td>
<td>0.6</td>
<td>1**</td>
<td>15***</td>
<td>15</td>
<td>15**</td>
<td>15*</td>
</tr>
</tbody>
</table>
Differences in prevalence rates of child maltreatment, as reported above, may not necessarily be the result of changes over time. Alternatively, they could be related to participants’ readiness to disclose, and to differences in defining maltreatment, in sampling, and in methodologies (Hobbs, 2005; Pereda et al., 2009a). Pereda et al. (2009a), for instance, reported that using multiple questions about a variety of specific traumatic experiences resulted in higher prevalence rates compared to fewer, broad questions. Nonetheless, these UK studies have shown that child maltreatment and sexual abuse, emotional abuse, neglect and – among adolescents and young adults – interpersonal partner violence are common phenomena.

This is not unique to the US and the UK. Meta-analyses have revealed that childhood maltreatment, and particularly child sexual abuse, is a global problem. Again, the numbers of reported victims is greater among girls and young women. Pereda, Guilera, Forns, and Gómez-Benito (2009b) found that internationally on average 19.7% of girls and 7.9% of boys experience child sexual abuse. Barth et al. (2013) reported child sexual abuse of 8-31% among girls and 3-17% among boys. And Stoltenborgh et al. (2015) reported international rates of 12.7% child sexual abuse (180/1000 girls, 76/1000 boys; no gender breakdown for other types), 22.6% physical abuse, 36.3% emotional abuse, 16.3% physical neglect, and 18.4% emotional neglect in children generally. Comparison between studies has been limited because various data collection tools have been used. Conversely, Mitchell, Finkelhor, Jones and Wolak (2010) argued for using data from national law enforcement agencies because they adopted clear standards for recording cases of crimes.

2.3.3. **Prevalence rates of interpersonal violence against women**

Research has shown that interpersonal violence continues to occur when girls grow into women, and boys grow into men. In 2016, the UK Office of National Statistics
(2016b) reported that 27.1% of women (4.5 million) compared to 13.2% of men (2.2 million) had experienced domestic violence since age 16 in England and Wales. In addition, 8.2% of women and 4.0% of men reported having experienced domestic abuse within the previous year. The most common types were non-sexual partner abuse (20.7%), stalking (20.2%) and sexual abuse (19.0%) experienced by women and stalking (9.8%) and non-sexual partner abuse (8.6%) experienced by men. The UK Office of National Statistics (2016b, p. 6) stated that the “largest difference between men and women was for experience[s] of sexual assault (including attempts) with women (19.0%) being 5 times as likely as men (3.8%) to have experienced it since the age of 16”. Similar to child maltreatment, domestic violence in the UK was not at all found to be an isolated occurrence and, again, women were considerably more frequently exposed to it than men. Unfortunately, the UK Office of National Statistics (2016b) only included England and Wales in their surveys. No definitive conclusions about the UK-wide extent of domestic and intimate partner violence can be made, but it is reasonable to assume the prevalence is similar.

Globally, figures have shown that interpersonal violence is also common in many societies. For example, a systematic review by Devries et al. (2013) reported that 30% of women had experienced physical and/or sexual intimate partner violence during their lifetime from age 15. Stöckl et al. (2013) reported intimate partner homicides at a global rate of 13.5%, while a staggering 38.6% were female homicides compared to 6.3% male homicides committed by an intimate partner. High-income countries in this study have shown higher rates of homicides with 14.9% for men and women combined, and 41.2% for women only. Stöckl et al. (2013) suggested that this may be the result of more data being available in these countries, and of better linkage between different systems that record homicides. Similarly, an international review by the World Health Organisation (WHO, 2013) has shown that worldwide 35.6% of women experienced physical and/or sexual violence by an intimate partner or non-partner, 30% of women experienced violence in a relationship, and 7.2% of women experienced sexual assault by a non-partner. High-income regions, such as Europe
and the western Pacific showed lower prevalence rates of 23.2% and 24.6%, respectively. This WHO report also confirmed what studies on child maltreatment have shown, namely that women’s experience of violence begins when they are young. Violence affected 29.4% in the 15-19 years age range, and gradually rose to 37.8% in women aged 40-44. Lifetime prevalence of sexual violence committed by someone other than a partner was highest among high-income regions at 12.6% and the African region at 11.9%, while South-East Asia had the lowest prevalence of 4.9%. For Europe, a rate of 5.2% for non-partner violence was reported. However, another report (Global Burden of Disease study mentioned in WHO, 2013) showed that 11.5%, 10.8% and 13.0% of women experienced non-partner sexual violence in Western Europe, central Europe, and North America, respectively.

Again, there were differences amongst these studies in defining domestic violence, intimate partner violence, sexual violence or rape, as well as in sampling and in collecting data making interpretation and comparisons difficult. For example, the WHO (2013) only included physical and/or sexual abuse in their analysis. Other limitations were the lack of data from conflict regions, studies of poor quality, absence of data (particularly population-based data) from certain countries, and that multiple and repeated violence experienced by women has not been addressed in reports (WHO, 2013). Nonetheless, global data have shown consistently that violence against women and children is a pressing, global and common problem of significant proportions (Abrahams et al., 2014; Alhabib, Nur, & Jones, 2010; May-Chahal & Cawson, 2005; Pereda et al., 2009a; Stoltenborgh et al., 2015, 2011; WHO, 2013).

2.3.4. Prevalence rates of developing post-traumatic stress after interpersonal trauma events

Many people do not develop psychological difficulties when exposed to any type of traumatic event. For example, Domhardt, Münzer, Fegert and Goldbeck’s (2015)
systematic review has shown that 10-53% of the child and adolescent population and 15-47% of the adult population reported resilience after experiencing childhood sexual abuse. Yet, Breslau et al. (1998) and Kessler et al. (1995) found that about 8% were at risk of developing post-traumatic stress disorder (PTSD). Despite men being more exposed to different traumatic events than women (60.7% men, 51.2% women), it is noteworthy that women were twice as likely to develop PTSD (10.4% women, 5% men) (Kessler et al., 1995). Blain, Galovski and Robinson (2010), Cloitre et al. (2010), and Kessler et al. (1995) suggested that this difference may be due to women being exposed to more interpersonal trauma events than non-interpersonal ones, and to more childhood abuse (particularly physical and sexual abuse) compared to men. Kessler et al. (1995), for example, found that the risk for developing PTSD was considerably higher in women assessed after experiencing rape (45.9%), molestation (26.5%), physical attacks (21.3%), being threatened with a weapon (32.6%), neglect (19.7%), and physical abuse (48.5%). The extent of interpersonal trauma that has been identified makes it a type of trauma particularly worthwhile studying in more detail.

To date, Kessler et al.’s (1995) study is the most comprehensive study including both, trauma events and a range of trauma symptoms. It also investigated a national sample (US) of adults. Unfortunately, no recent study of this kind exists for a UK population. Future studies should also address the limitation that Kessler et al.’s (1995) study relied on a PTSD diagnosis to establish the prevalence of becoming traumatised. This shortcoming ignored individuals with a diagnosis of DESNOS or general anxiety, or those who were traumatised but were given another diagnosis or no assessment (van Ee, Kleber, & Jongmans, 2016). Other limitations to studies more generally remain a problem. Participants’ choice to disclose or not disclose traumatic experiences, individuals’ choice to seek help (and be assessed and diagnosed), their choice to take part in studies, and reliance on retrospective accounts and self-reports all imply that prevalence rates may be underestimated across populations.
2.4. Differentiating types of traumatic event

It is notable in this review of prevalence that studies have not only defined each type of traumatic event (e.g., physical abuse, neglect) differently, but have also included different traumatic events within the overall category of interpersonal trauma. These differences in definitions will be discussed in this section.

2.4.1. Defining child sexual abuse

There are different criteria for what constitutes physical, sexual and emotional abuse, neglect, domestic and intimate partner violence. For example, the systematic review by Pereda et al. (2009b, p. 337) found that most studies on child sexual abuse included “either contact or non-contact sexual experiences between a person under 18 years of age and an adult or other person at least 5 years older; or sexual experiences resulting from coercion, no matter what the age of the person”. However, some studies in their review included only cases of incest or rape and excluded experiences of other abuse like forced intercourse in intimate relationships among adolescents or unwanted exposure to pornographic material. Pereda et al.’s (2009b) definition has also demonstrated that some studies included contact sexual experiences but excluded non-contact sexual experiences. Definitions have also differed with regards to the relationship of the victim to the perpetrator and their age, and the age of the abused child or adolescent. For example, Cloitre et al. (2005) regarded exposure to sexual contact before 18 years of age as problematic only if it was committed by a caretaker or person in authority. However, this would exclude non-contact sexual experiences or forced sexual experiences with a sibling or peer. There have also been differences in including completed vs. attempted sexual experiences, and other studies have limited child sexual abuse to age 16 or under (May-Chahal & Cawson, 2005).
2.4.2. Defining child physical abuse

In terms of child physical abuse, definitions have tended to set the age limit at 16 or 18, and have regarded parents or guardians or caretakers as perpetrators (e.g., Cloitre et al., 2005). Thus, they have excluded physical violence committed by siblings, peers or strangers. Perhaps this is because these experiences may be understood instead as intimate partner violence or rape. The distinction is not clear and may well distort prevalence rates. Physical abuse against children has also tended to mean intentional behaviour consisting of direct physical force or with objects that caused specific injuries (Cloitre et al., 2005; May-Chahal & Cawson, 2005). Furthermore, current definitions have disregarded the continuum of physical maltreatment ranging from an occasional slap on the hand or bottom to regular, violent punishment with a belt or stick. Generally, it has been understood that more severe and frequent forms of physical force are considered abusive (May-Chahal & Cawson, 2005). However, the point at which physical interference stops being an acceptable practice of disciplining and parenting, and becomes unacceptable violence has not been defined clearly (Hobbs, 2005; Stoltenborgh et al., 2015). Equally, it is concerning for only intentional, but not unintentional, behaviours consisting of physical force to be included in the category of physical abuse, particularly when assessing subsequent trauma in survivors. Firstly, the child victim or adult survivors may not be able to distinguish between another person’s intentional or unintentional violent behaviour. Secondly, the caretaker who uses physical force may only act in response to a sudden strong emotion, making this an unplanned reaction. Thirdly, unintentional physical force may be as traumatising as intentional force; but if research only asks victims or survivors about exposure to intentional violent behaviour, then such research will be dismissing unintentional physical abuse as traumatising.
2.4.3. Defining child emotional or psychological abuse

Similarly, there is a continuum of emotional or psychological abuse ranging from less severe or mild and infrequent emotional harm to severe and frequent. May-Chahal and Cawson (2005) suggested that emotional abuse should be understood as a broad phenomenon rather than a few specific isolated events. This would mean that occasional, infrequent harsh words are less abusive. According to Denholm et al. (2013, p. 342) emotional abuse by caregivers tends to include “behaviour that conveys to a child that he/she is worthless, flawed, unloved, unwanted, endangered or valued only in meeting another’s needs” or, according to May-Chahal and Cawson (2005, p. 973), “different aspects of control, domination, humiliation, withdrawal, or threat”. Again, there is ambiguity with regards to when behaviour and words are acceptable parenting practices to discipline the child and when they are regarded as harmful to the child’s development. Disagreement also exists as to whether intentional or unintentional behaviour is regarded as emotional abuse (Denholm et al., 2013).

2.4.4. Defining child neglect

Like emotional abuse, childhood neglect may be difficult to detect. It has also been difficult to measure, conceptualise and identify because the harm is unseen due to omission of action. In this regard, Hobbs (2005, p. 950) highlighted the problem by asking: “How does the subject measure the level of care they have received and compare it against a norm they have never experienced?”. Other authors attempted to define child neglect. Denholm et al. (2013), for instance, suggested that neglect can be understood as failing to meet a child’s basic need. Neglected basic needs may refer to lack of emotional support, physical and medical care, and education, as well as inadequate or absent food, hygiene, clothing, shelter, or safety through absent care suitable to the child’s age and living situation (Denholm et al., 2013; May-
Chahal & Cawson, 2005). There are continuing debates about what type of omission of care and to what extent, frequency or severity neglect is harmful to the child (May-Chahal & Cawson, 2005).

2.4.5. Defining intimate partner violence

With regards to intimate partner violence and domestic violence, both terms are often used interchangeably. Though, there are some distinctions. Intimate partner violence and domestic violence tend to be used to refer to both physical and sexual abuse within an intimate relationship. While some studies only included physical and sexual abuse (WHO, 2013), researchers acknowledge that intimate partner violence and domestic violence tended to be accompanied by emotional abuse (Devries et al., 2013; WHO, 2013), and coercive control including financial control and stalking. For example, the UK Office of National Statistics (2016b) have considered these additional experiences in their more recent survey and included abuse not only committed by a partner, or ex-partner but also by family members. The term rape is used to mean non-partner sexual violence with anyone other than a partner (WHO, 2013). This may include trafficking and harassment (Abrahams et al., 2014), and committed or attempted sexual acts without the woman’s consent (WHO, 2013). Yet, again, disagreements over definitions exist with regards to rape.

2.4.6. Further critique of definitions

Differences in conceptualising types of child maltreatment and adult abuse are problematic. Firstly, it has been difficult to compare studies investigating specific traumatic events (e.g., child sexual abuse, intimate partner violence), as well as studies investigating child maltreatment or interpersonal violence in adulthood more generally. Secondly, using different criteria (such as who counts as a
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perpetrator) may hide other sources of abuse. For example, Finkelhor et al. (2014) suggested that defining childhood sexual abuse as committed only by adults or as committed by anyone (without breaking it down in subgroups) is misleading to policy makers because such research results will not reveal that a considerable amount of child sexual abuse is committed by peers. Thirdly, research may also fail to detect traumatic effects from other types of abusive behaviours which that study did not specifically enquire about, perhaps because it was not considered abusive or neglectful or otherwise detrimental to child development or the adult’s well-being at the time. Fourthly, most research has used questionnaires to enquire about child maltreatment and adult abuse and, therefore, may not capture incidents hidden by the survivor’s dissociation or suppressed memory. It was the researchers who decided whether participants’ ratings should be regarded as maltreatment or not. Finally, there may be a difference between professionals’ or researchers’ understanding of what counts as abusive behaviour, and trauma survivors’ perception of abusive and traumatic incidents.

Definitions of physical, sexual and emotional abuse across age ranges, and what constitutes neglect in childhood have evolved and continue to change as more is understood about what behaviour is potentially harmful to women and children. While experiences of different types of violence can be objectively defined to a certain degree (e.g., Have you experienced sexual intercourse/penetration before the age of 12?), there are also subjective factors determining if violence against another person has occurred (e.g., Have you had severe/frequent injuries as a result of physical disciplining by caregivers? – But what is a severe injury? What is regarded as frequent; and compared with what?) (Hobbs, 2005). What is more, our understanding of violence is determined by cultural and social norms, differs across families, communities and countries, and is subject to change (Hobbs, 2005; Koss, Heise, & Russo, 1994; Pereda et al., 2009a; Stoltenborgh et al., 2015, 2011; WHO, 2013).
2.4.7. Defining interpersonal trauma

How do these different types of traumatic events relate to the concept of ‘interpersonal trauma’? Most studies have merged the previously discussed types of violence against women and children under the generic term ‘interpersonal violence’ and regarded the resulting psychological difficulties broadly as ‘interpersonal trauma’. However, this definition has differed depending on which types of abuse were included. For example, earlier studies considered physical abuse, sexual abuse, and domestic or intimate partner violence as risk factors for interpersonal trauma (Cloitre et al., 2009, 2010; Forbes et al., 2012; Hegadoren et al., 2006; Iverson et al., 2011; Lasiuk & Hegadoren, 2006; Scott, 2007). However, limiting studies of interpersonal trauma to these types of incidents ignored evidence that severe harm can also be caused in incidents of neglect and emotional abuse, particularly in childhood (Briere & Rickards, 2007; Cloitre et al., 2009; Dorahy et al., 2009; Lind, Delmar, & Nielsen, 2014; Steuwe et al., 2014). Therefore, Ehring and Quack (2010) have proposed to include these experiences in the definition of interpersonal trauma.

In fact, several of the more recent studies and systematic reviews on adverse childhood experiences have included sexual abuse (irrespective of the perpetrator being known to the victim or not), physical and emotional abuse by a caregiver, neglect by a caregiver (either unspecified neglect, or distinguished into emotional and physical neglect), and witnessing any abuse towards a caregiver (e.g., Centers for Disease Control and Prevention, 2016; Denholm et al., 2013; May-Chahal & Cawson, 2005; Radford et al., 2013; Stoltenborgh et al., 2015). With regards to violence against adult women, recent studies have included incidents of sexual abuse (again, irrespective of the relationship to the perpetrator), and physical and/or emotional abuse by a partner or former partner (UK Office for National Statistics, 2016b; WHO, 2013). Occasionally, financial and coercive control has been regarded as traumatic (e.g., Howard & Skipp, 2015). By contrast, neglect and the witnessing of
abuse experienced by adult women have not been understood as traumatic. The reason for there being a difference between adult and child maltreatment may be that a child is dependent on an adult caregiver to provide emotional and physical care for survival. Therefore, to witness this caregiver being threatened or to have emotional and physical needs neglected by the caregiver threatens the child’s survival and, thus, may be traumatic.

While consensus has not been reached regarding what kind of traumatic events should be deemed ‘interpersonal’, there has been general agreement that incidents such as vehicle accidents, physical injuries, life-threatening illnesses and natural disasters are excluded (Blain et al., 2010; Breslau et al., 1998; Kessler et al., 1995). However, some events are more ambiguous. For example, it is unclear whether interpersonal trauma should include combat or torture experiences (e.g., Ebert & Dyck, 2004) and witnessing abuse (e.g., Beals et al., 2013). This ambiguity in definition implies that more research is needed to analyse and classify the full complexity of interpersonal traumas.

Although researchers have associated exposure to different types of interpersonal violence with interpersonal trauma, not everyone exposed to these events will develop trauma symptoms. The next section will examine more closely how survivors of traumatic events respond psychologically.

2.5. Importance of studying interpersonal trauma

Some individuals remain resilient; that is their daily functioning is not impaired after being exposed to traumatic events (Charuvastra & Cloitre, 2008; Chouliara et al., 2014; Joseph, Murphy, & Regel, 2012; Stockton, Hunt, & Joseph, 2011). However, those who do not remain resilient may develop maladaptive responses that can
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severely impair their life. The following paragraphs explore the cost to health and quality of life for the individual survivor and the costs for society.

2.5.1. Developing trauma symptoms (PTSD, DESNOS, complex trauma)

Survivors of child maltreatment, intimate partner violence, domestic violence or rape are known to develop trauma symptoms that fit the criteria for PTSD, trauma- and stress-related disorder, DESNOS or complex PTSD (e.g., Cloitre et al., 2013; Ford, Stockton, Kaltman, & Green, 2006; van der Kolk et al., 2005). Individuals may re-experience the event, avoid situations triggering memories, feel emotionally numb, and experience hyperarousal – characteristics associated with PTSD (American Psychiatric Association, 2007; Cloitre et al., 2011; Courtois, 2014; Dorahy et al., 2009; Ford et al., 2005; Herman, 1992). While trauma symptoms also manifest themselves after non-interpersonal traumatic events (e.g., Kessler et al., 1995), survivors exposed to trauma of interpersonal nature show some striking differences. According to Briere, Kaltman and Green (2008), Cloitre et al. (2013, 2005), Courtois (2004), Ford et al. (2006), Herman (1992), Kessler (2000); Radford et al. (2013), and Scott (2007), short-lived and less severe trauma symptoms have been associated with single trauma events, such as non-interpersonal traumas (e.g., accidents); whereas interpersonal trauma events have been associated with more severe and longer lasting trauma symptoms. For example, Scott’s (2007) study found that participants receiving therapy had been exposed to significantly more multiple trauma events and showed higher scores of PTSD than a control group. There was a particularly high risk of developing PTSD after child sexual abuse compared to people who had no history of exposure to childhood sexual abuse. Similarly, Dutton, Kaltman, Goodman, Weinfurt and Vankos (2005) found that female victims of intimate partner violence showed the highest prevalence rates for PTSD when high levels of physical, sexual as well as psychological abuse and stalking had occurred. This suggests that the severity of subsequent symptoms increased with
repeated and cumulative exposure to interpersonal trauma events, such as child maltreatment, intimate partner violence and domestic violence. The exception is physical or sexual assault where more severe trauma symptoms develop even when the assault has occurred as single event (e.g., Betts, Williams, Najman, & Alati, 2013; Faravelli, Giugni, Salvatori, & Ricca, 2004; Zinzow et al., 2012). In this regard, Faravelli et al. (2004) showed that women who had experienced a single rape were significantly more likely to develop PTSD and other mental health problems than women with multiple experiences of non-interpersonal trauma events.

Daily functioning after such cumulative and interpersonal type trauma events may be further impaired by emotion regulation difficulties, disturbances in relational capacities, alterations in attention and consciousness, adversely affected belief systems, and somatic distress or disorganisation – often understood (and contested) as Disorder of Extreme Stress Not Otherwise Specified (DESNOS) (e.g., Cloitre et al., 2009, 2005; Courtois, 2004; Dorrepaal et al., 2012; Ehring & Quack, 2010; Ford et al., 2005; Scoboria et al., 2008; van der Kolk et al., 2005). Such complexity of symptoms implies that there might be additional levels to post-traumatic stress. Indeed, Cloitre et al. (2013), Ford et al. (2006) and van der Kolk et al. (2005) found that trauma symptoms may lie on a spectrum from (1) low and PTSD-only symptoms – mostly following single and non-interpersonal traumatic events – to (2) severe PTSD symptoms including some degree of dysfunction with regards to emotion regulation, interpersonal difficulties and negative self-beliefs (also related to more severe DESNOS symptoms) – mostly in cases of later-onset interpersonal trauma events (e.g., abuse in adulthood), and then to (3) severe PTSD symptoms and severe additional self-regulatory dysfunction (even higher levels of DESNOS symptoms) – mostly in cases of early-onset interpersonal trauma events (e.g., childhood maltreatment). For example, van der Kolk et al. (2005) found that, for participants with early onset interpersonal abuse, the lifetime prevalence of PTSD and DESNOS combined was 61% compared to PTSD alone (16%). This was significantly different to participants with late onset interpersonal abuse where 33% had PTSD and DESNOS, and 26% had
PTSD only. This second group differed significantly again from a third group of participants with only non-interpersonal abuse experiences where 15% met criteria for PTSD alone, but only 8% had PTSD and DESNOS combined.

Evidence has suggested that the cost to the individual trauma survivor of interpersonal violence is not only more severe and longer lasting post-traumatic stress symptoms but also increased difficulties in self-regulating emotions, relationships, attention, thoughts and beliefs, and somatic distress. At the same time, research has shown that not all survivors of interpersonal trauma develop severe or any post-traumatic stress symptoms. In van der Kolk et al.’s (2005) study, for instance, 16% of this group ‘only’ developed PTSD, while 23% appeared to have no life time diagnosis of PTSD and/or DESNOS.

2.5.2. Developing additional mental health problems

Further research has shown that women and children who have experienced interpersonal violence are at risk of developing a range of other mental health problems in adulthood which add to the long-term damage borne by these individuals. For instance, Felitti et al. (1998) found that survivors of child maltreatment were 4-12 times more at risk of alcohol and drug abuse, depression, and suicide attempts. Steine et al. (2017) reported that self-reported symptoms of post-traumatic stress, anxiety, depression, dissociation, eating disorders, insomnia, nightmare related distress, physical and emotional pain, relational difficulties, and self-harm behaviours as well as symptom complexity significantly increased the more cumulative childhood maltreatment a person experienced. Similarly worldwide, women of non-partner sexual abuse “are 2.3 times more likely to have alcohol use disorder and 2.6 times more likely to experience depression or anxiety than women who have not experienced non-partner sexual violence” (WHO, 2013, p. 32).
Addictions

A strong association has been found between addiction and traumatic event exposure or post-traumatic stress. For instance, Ullman et al. (2013) found that an experience of adult sexual assault in a female population as well as a diagnosis of PTSD predicted difficulties with alcohol and drug use; although, substance misuse did not mediate PTSD symptoms. There were also differences in using alcohol and/or drugs as a coping strategy depending on the trauma experienced: interpersonal traumas and increased severity (i.e., both childhood and adulthood trauma) predicted stronger links to both problem drinking and drug use than non-interpersonal trauma experiences. Similarly, Nathanson, Shorey, Tirone and Rhatigan (2012) found that women with a history of intimate partner violence met criteria for PTSD and alcohol abuse (11.7%), as well as for substance abuse and depression (12.7%). This may indicate that alcohol and drug dependency are a way for trauma survivors to self-medicate in order to reduce the cognitive, behavioural and emotional difficulties of PTSD and depression (Nathanson et al., 2012).

Underlying mechanisms have been proposed by Lijffijt, Hu and Swann (2014), who suggested there may be a behavioural shift from initial experimentation to regular use of substances, followed by dependency and attempts to abstain but with relapses. These may occur alongside neurological effects on dopaminergic reward systems. Yet, these studies have also shown that not all trauma survivors developed addictions to drugs or alcohol. Instead, other protective factors may play a role or survivors’ trauma may manifest itself in other disorders.

Depression

Further links have been established between depression and traumatic event exposure or post-traumatic stress (Felitti et al., 1998; Jonas et al., 2011; Pratchett & Yehuda, 2011; WHO, 2013). For instance, Kessler et al. (1995) reported that 48.5% of women in the general population and 47.9% of men (irrespective of the type of traumatic events they had experienced) were diagnosed with both PTSD and depression. Nathanson et al. (2012) reviewed studies on depression in women after
intimate partner violence and found a diagnostic range of 35%-70%. By contrast, Taft, Resick, Watkins and Panuzio (2009) found that exposure to childhood sexual abuse was more likely to be associated with PTSD only than with PTSD and depression. However, they argued that comorbidity of PTSD and depression was predicted by ‘distorted trauma-related beliefs’ and dissociation most strongly. This finding suggests that it is not the abusive event per se that is related to concurrent symptoms of PTSD and depression, but that this combination may be due to the development of distorted beliefs and dissociation. Depression in female trauma survivors has been associated with further difficulties, such as an inability to maintain or form new relationships and a tendency to isolate and stop seeking social support (Nathanson et al., 2012).

**Dissociation**

In addition, dissociation has been linked to traumatic event exposure or post-traumatic stress. For example, Zucker et al. (2006) found that among adults who had been exposed to different traumatic events in the past and were currently diagnosed with PTSD, those also diagnosed with DESNOS showed more dissociative symptoms than adults diagnosed with PTSD alone. While this study did not take into account the type of trauma (i.e., non-interpersonal, early onset interpersonal, late onset interpersonal), the researchers observed a “non-significant trend towards those with DESNOS having been younger at the time of their trauma”, and suggested that more severe dissociation was linked to early onset interpersonal trauma (Zucker et al., 2006, p. 25). Carlson, Dalenberg and Mcdade-Montez’s (2012) review also documented ample evidence showing a relationship between dissociation and PTSD. It is noteworthy that these studies showed a reduction in dissociation over time following exposure to traumatic events, and that this decline was greater for non-sexual assault cases than for sexual assault cases. It could be postulated that dissociation serves as a coping mechanism for trauma survivors enabling them to find refuge in another internal world, disconnected from the present and from previous stressful events.
Other concurrent psychological difficulties

Substance dependency, depression and dissociation have been frequently documented as psychological difficulties that have developed after interpersonal trauma or as comorbid conditions with PTSD. However, a history of interpersonal trauma exposure, PTSD, trauma- and stress-related disorder, DESNOS or complex PTSD also co-exist with eating disorders (e.g., Jonas et al., 2011; Mitchell et al., 2012), anxiety (e.g., Jonas et al., 2011; WHO, 2013), self-harm (e.g., Martin et al., 2016), suicide attempts and actual suicides (e.g., Briere, Madni, & Godbout, 2016; Castellví et al., 2017), and personality changes such as Borderline Personality Disorder among others (e.g., Pratchett & Yehuda, 2011; Resick et al., 2012).

It has been suggested that these mental health problems following trauma may be the result of a deficit in the ability to self-regulate distress (Herman, 2012). That is, instead of diagnosing and treating those psychological difficulties in isolation with “multiple comorbid diagnoses and multiple overlapping treatment protocols”, thus risking having overlooked a history of trauma (Herman, 2012, p. 257; Lommen & Restifo, 2009; Read, Brown, & Kahler, 2004; Resnick, Bond, & Mueser, 2003), it may be better to view them as different coping responses to severe distress for which trauma survivors have not developed the basic skills needed to enable them to regulate their feelings, thoughts, beliefs and behaviours. Coping skills and deficits will be discussed further in section 2.7.

2.5.3. Developing physical health problems

Furthermore, links between traumatic event exposure or post-traumatic stress and poor physical health or health behaviour have been established. A noteworthy early study investigated the effects of childhood maltreatment in later life in a large US national sample (Felitti et al., 1998). Felitti et al. (1998) found that child maltreatment
increased the prevalence of smoking, poor self-rated health, having 50 or more
sexual intercourse partners, sexually transmitted disease, physical inactivity, and
severe obesity. The more experiences of childhood maltreatment these adults
reported the more adult diseases they presented with, including ischemic heart
disease, stroke, chronic lung disease, diabetes, fractures, and hepatitis. More recent
studies have reported similar findings. For example, Coughlin (2011), Spitzer,
Meyer and Herrmann-Lingen (2016) and Suglia, Sapra and Koenen (2015) reviewed
research evidence and found that childhood maltreatment was associated with
developing cardiovascular disease in later life. Similarly, Forbes et al. (2015) showed
that adults diagnosed with PTSD were more likely to develop both smoking habits
and significant drinking problems after their first exposure to traumatic events.
There is also emerging evidence that cumulative exposure to traumatic events, such
as child maltreatment, has changed trauma survivors’ neuroendocrine and immune
system as well as their genetic profile and, thus, increased their risk of physical ill-
health and of passing on these altered stress responses to the next generation (De
Bellis & Zisk, 2014; Nugent, Goldberg, & Uddin, 2016; Ramo-Fernández, Schneider,
Wilker, & Kolassa, 2015). With regards to abuse in adulthood, the WHO (2013) found
that, globally, women exposed to physical or sexual abuse by their partner were 16% 
more at risk of having a low-birth weight baby, were more than twice as likely to
miscarry a pregnancy, and were 1.5 times more at risk of acquiring HIV in some
parts of the world than women not exposed to partner violence. Pregnancy during
adolescence, unplanned pregnancy in general, cancer and cardiovascular diseases
have also been associated with exposure to intimate partner violence. What is more,
Stöckl et al. (2013) demonstrated that intimate partner violence can cost women’s
lives – 38.6% of homicides were committed against women partners worldwide.

Unfortunately, most studies associating PTSD with physical disease have not
indicated whether post-traumatic stress originated from non-interpersonal or
interpersonal trauma events and whether developing physical illnesses differed
depending on the type of traumatic events (e.g., Forbes et al., 2015; Lohr et al., 2015).
Nonetheless, research has begun to identify that effects on physical health are not the same for all types of trauma experiences. Spitzer et al. (2016), for example, argued that childhood emotional abuse appears to have a greater and independent effect on adult health compared with other types of child maltreatment; and that emotional abuse might perpetuate the negative effects of other forms of abuse. Similarly, Jackson et al. (2016) found in a sample of fostered adolescents that those who had experienced sexual abuse, neglect, or general trauma had more medical visits than those who had experienced physical or psychological abuse. Further research needs to consider evidence from medical examinations not just from participants’ self-rated responses (Spitzer et al., 2016) and evidence from prospective investigations (Nugent et al., 2016).

2.5.4. Impact on and of education, employment and other social factors

Some studies have reported a negative impact on survivors’ educational and work performance. A review by Maguire et al. (2015) found that children affected by neglect and emotional abuse score lower on general intelligence, and performed less well in literacy, mathematical and attention tasks than their peers; and one reviewed study showed that children, who were both physically abused and neglected, were more likely to repeat a school year. Lower educational performance, particularly for neglected children and adolescents, was mirrored in a review by Romano, Babchishin, Marquis and Fréchette (2015). Similarly, Perfect et al. (2016) reviewed studies showing cognitive, attentional, verbal and academic impairment in traumatised children and adolescents (including exposure to child maltreatment and community violence), and suggested that this may result in lower educational achievement. These authors criticised the fact that several individual studies did not distinguish between exposure to trauma events and the symptoms resulting from such exposure. This lack of clear definitions and explanations have made it difficult to ascertain whether low educational achievement is due to trauma event exposure
or due to subsequent traumatic symptoms. Again, some of these studies indicated that academic outcomes may differ depending on the specific type of maltreatment experienced. However, I have not been able to identify any research that has taken a systematic approach to studying such differences.

Falling behind in school has consequences for maltreated traumatised children and adolescents when they reach adulthood. Because greater educational achievement tends to result in better employment and work opportunities, educational impairment due to childhood traumas can lead to negative, long-term outcomes such as less well paid jobs, unstable employment, part-time jobs, loss of work days due to illness in adulthood all of which had resulted from child maltreatment (Kezelman, Hossack, Stavropoulos, & Burley, 2015). Employment instability is also experienced by adult survivors of domestic violence. In this regard, Showalter’s (2016) review found frequent disruption at work, harassment on the job, loss of paid work time, job losses and unemployment among women experiencing intimate partner violence.

2.5.5. Economic costs to society

There is ample evidence that individual trauma survivors face multiple and complex impairments. These factors will ultimately affect society as a whole and generate economic and social costs. The total lifetime cost of new cases of nonfatal and fatal child maltreatment in the US has been estimated at $585 billion for 2008 (Fang et al., 2012). Per victims, this included $32,648 in childhood health care costs; $10,530 and $14,100 in medical costs (for non-fatal and fatal maltreatment, respectively); $144,360 and $1,258,800 in productivity losses (for non-fatal and fatal maltreatment, respectively); $7,728 in child welfare costs; $6,747 in criminal justice costs; and $7,999 in special education costs (Fang et al., 2012, p. 156). In the UK, the economic costs for childhood sexual abuse alone were estimated at £1.6 billion in
2012 (Saied-Tessier, 2014). These figures included £91 million for child and adult health, £97 million for criminal justice system, £57 million for services for children, and £1,350 million lost productivity. This report also suggested human and emotional costs of £0.9 billion (low estimate). The authors assumed that this estimate is conservative and known costs have been incurred in other areas that were not considered or for which data were unavailable. Costs for domestic violence in England and Wales have been estimated at £15,730 million in 2008 with £3,856 million for services, £1,920 million for lost economic outputs, and £9,954 million for human and emotional costs (Walby, 2009).

While there have been several detailed research reports on the estimated economic burden of child maltreatment and domestic violence in other developed countries (e.g., Fang et al., 2012, in the US; Fromm, 2001, in the US; Kezelman et al., 2015, in Australia; Thiel et al., 2016, in the Netherlands; Wang & Holton, 2007, in the US), economic estimates of child maltreatment and domestic violence in the UK have not only been scarce but also quite limited in scope. Firstly, they only investigated childhood sexual abuse, and did not include other forms of child maltreatment. This resulted in inaccurate and low estimates of costs. Secondly, economic estimates included costs for common health-care issues (especially mental health) but not for physical health issues (e.g., heart disease and lung disease) as found by Felitti et al. (1998) or Spitzer et al. (2016) and for poor health behaviours (e.g., smoking and lack of exercise) as found by Felitti et al. (1998) or Forbes et al. (2015). Thirdly, studies have only referred to annual costs without considering life time costs per individual, and have just considered the costs of new cases without including costs for those suffering long-term problems from previous incidents. Fourthly, Walby’s (2009) study referred to statistics from England and Wales so cost estimates have not given a picture of the UK as a whole. Finally, UK-based studies have not considered costs for prevention and cases of adult sexual assault by a non-partner. This is problematic because it underestimated the true economic costs of trauma resulting from childhood maltreatment and victimisation in adulthood. Where governments
and funding authorities rely on these estimated figures in order to address child maltreatment and violence against women, these areas will be underfunded and necessary resources will not be available. Improved estimates of the economic and human costs are urgently needed to inform governments, and social and health care services on funding requirements.

In comparison, the economic costs of other common health-care problems have been estimated to be lower while being better funded than the costs resulting from interpersonal violence and trauma. One study by Waechter and Ma (2015) showed that incidents of rape of women (1.9 million in 2013, US) and sexual violence other than rape of women (12.3 million) were both greater than the incidence of cardiovascular disease (1.52 million, men and women combined), cancer (1.604 million, men and women combined), diabetes (1.7 million, men and women combined), or HIV/AIDS (0.0475 million, men and women combined). They also found that the reported economic burden for rape, attempted rape and all violence ($921.72 billion, US, annually) was considerably greater than that for cardiovascular disease ($537.59 billion), cancer ($235.2 billion), diabetes ($248.6 billion) and HIV/AIDS ($47.1 billion). Investment in the US for research, treatment and prevention programmes targeting violence and sexual abuse has been disproportionately low in relation to these estimated economic costs. Waechter and Ma (2015) found that research, treatment and prevention addressing rape, attempted rape and all types of violence received $0.822 billion in funding – the lowest investment of all despite incurring the highest cost. In comparison, cardiovascular disease received $1.969 billion in funding, cancer received $5.604 billion – the highest of all despite incurring only relatively moderate to low economic burden –, diabetes received $1.013 billion funding and HIV/AIDS received $3.639 billion funding – the second highest investment despite incurring the lowest economic burden compared to the other major health problems. Interestingly, the risk in the population of suffering the better-funded health care problems (such as cardiovascular disease, cancer, diabetes, or HIV) has either been
equal for men and women or a greater risk for men, while the underfunded public health issues of rape, attempted rape and violence are predominantly a risk to women (Waechter & Ma, 2015).

The study by Waechter and Ma (2015) investigated data from the US. There does not appear to be a comparable study of the economic costs of different health problems, including interpersonal trauma, and investment in research, treatment and prevention in the UK. The reasons for such apparent disparity in investment for survivors of trauma and abuse compared with other major health problems are multiple and complex. Further research is needed to explore and quantify the full economic costs of this currently under recognised but major health and societal problem.

2.6. Underlying mechanism I: Attachment

2.6.1. Attachment theory and human development

While it is important to recognise why there is a need to study interpersonal trauma, it is also important to understand what explains these severe impairments in individual survivors following interpersonal violence. Attachment theory provides a framework for such an explanation. It postulates that humans have an innate system for survival which is activated when exposed to danger, threat or novelty (Bowlby, 1969, 1982). For a child, activation of this system prompts him or her to seek out their caregiver for comfort and safety. This increases their chance of survival. An attuned and responsive caregiver will protect the child, care for him or her and provide guidance on how to navigate the world. In turn, this deactivates the child’s attachment system and they are ready to explore their environment again. Longer term, continued responsiveness to the child’s distress will lead to secure attachment (Ainsworth, 1973). On the other hand, unresponsiveness, misattunement or even danger originating from a caregiver keep the child’s attachment system
activated and hold them in distress and unable to explore or mature. Where this dysfunctional pattern of caretaking persists, the child develops insecure attachment styles (Ainsworth, 1973).

A person’s attachment style influences how they engage with and perceive the world. Mikulincer, Shaver and Pereg (2003) argued that children with secure attachment tend to feel optimistic about managing distress, have a sense of trust in the benevolence of others and feel able to deal with danger. These children have learned that difficulties can be overcome, that others have good intentions and that one can influence the outcome in dangerous situations. They also tend to be more able to acknowledge and express feeling upset or needing support, and to use problem- and emotion-focused coping strategies.

By contrast, it has been proposed that children with insecure attachment styles display anxious, avoidant or disorganised behaviour (Ainsworth, 1973). Anxiously attached children may have negative views of others and themselves, fear rejection, seek greater intimacy in relationships (Lim, Adams, & Lilly, 2012), anticipate danger in most situations and overestimate the likely negative outcome of these situations (Mikulincer et al., 2003). Children with avoidant attachment tend to feel uncomfortable with intimacy, and prefer to be independent from others and self-reliant (Lim et al., 2012). Children with disorganised attachment tend to move back and forth between anxious and avoidant attachment behaviour. Over time, the child internalises these attachment experiences, and a dynamic internal working model of oneself, others and the world forms. Schemas or mental representations of this model determine how the individual perceives and interacts with their environment (Bowlby, 1969, 1982; Bryant, 2016; Sandberg, Suess, & Heaton, 2010; Schore & Schore, 2008; Woodhouse et al., 2015). As such, attachment contributes significantly to a person’s development of physiological, emotional and cognitive self-regulation, coping styles, and social skills (Schore & Schore, 2008). According to Bryant (2016), insecure attachment has been regarded as ‘secondary attachment strategies’ when
initial innate strategies of seeking proximity have failed. Consequently, insecurely attached children may become maladapted and develop problematic behaviours, emotions and cognitions.

2.6.2. Relationships between child maltreatment, attachment and trauma severity

With regards to interpersonal trauma, there is ample research evidence suggesting that child maltreatment predicts insecure attachment, and that insecure attachment predicts post-traumatic symptoms. For example, Jardin et al. (2017) found that insecure attachment to mother or father significantly moderated trauma symptoms in adolescents with a history of childhood sexual abuse. Additionally, adolescents with insecure attachment and a history of sexual abuse reported significantly higher levels of trauma symptoms than adolescents with secure attachment and an experience of sexual abuse, and higher than adolescents with no experience of sexual abuse. Another study, by Ogle et al. (2015), reported a strong relationship between trauma symptoms and attachment anxiety in a community sample of older adults with current PTSD symptoms and childhood abuse compared to individuals with PTSD symptoms and adult abuse. They also showed that avoidant and anxious attachment in these individuals was associated with more severe PTSD symptoms. Schimmenti and Bifulco (2015) found that anxiety disorder in a sample of adolescents and young adults was associated with emotional neglect (i.e., cold and critical parenting) mediated by anxious-ambivalent attachment. Other studies have reported behavioural, emotional and interpersonal problems in infant and toddlers, and in pre-schoolers who experienced domestic violence, and these problems may reflect attachment difficulties (e.g., Cunningham & Baker, 2004; Lundy & Grossman, 2005). Last but not least, unresolved attachment from trauma in childhood has been shown to increase the chance of developing PTSD by 7.5 times (Stovall-McClough & Cloitre, 2006).
On the other hand, there has also been experimental evidence that secure attachment can be activated (e.g., by showing a picture of a mother holding her child) and results in positive outcomes, such as minimising threat and pain perception, increased prosocial behaviour, and reduced physiological responses to stress and neurological responses to pain (Bryant, 2016). Additionally, Domhardt et al. (2015) referred to evidence showing that secure attachment with peers and parents as well as stability in the home was related to less severe effects after childhood sexual abuse, and to adaptive coping and greater resilience.

2.6.3. Relationships between abuse in adulthood, attachment and trauma severity

Similarly, research evidence has suggested that insecure attachment is associated with abuse in adulthood. A meta-analysis by Woodhouse et al. (2015) showed a relationship between secure adult attachment and lower levels of trauma symptoms, and a relationship between insecure adult attachment and greater trauma symptoms. In particular, anxious or fearful attachment was significantly associated with post-traumatic symptoms whereas dismissive or avoidant attachment was only moderately associated with post-traumatic symptoms. The types of measures (interviews versus questionnaires) that were used to assess PTSD influenced these associations. Unfortunately, this analysis included a range of traumatic experiences so that characteristics unique to interpersonal violence could not be determined. Female participants were overrepresented in these studies. The authors also criticised that effect sizes were often not reported resulting in relevant studies to be excluded from their analysis.

When adding the factor of exposure to interpersonal violence to the combination of attachment style and PTSD severity, studies have confirmed the pattern of avoidant
attachment as being related to maltreatment as well as trauma severity. For instance, Brenner and Ben-Amitay (2015) found that women with anxious, but not avoidant, attachment and a history of childhood sexual abuse were more likely to report sexual revictimisation in adulthood. This has been supported by similar research findings from Karantzaz et al. (2016) showing that anxiously attached young adults were more likely to be victims of sexual coercion than young adults with an avoidant attachment pattern. The authors suggested that adults with anxious attachment might be more likely to participate in sexual coercion because this group may gain a sense of intimacy and feel more secure as a result and thus avoid rejection. Anxious but not avoidant attachment was also partially associated with intimate partner violence and trauma symptoms among young women as well as with adolescent or adult victimisation and trauma symptoms in this group (Sandberg et al., 2010). Woodhouse et al. (2015) discussed literature suggesting that avoidant attachment may be a protective factor and result in lower PTSD symptom severity because survivors avoid anxiety-provoking relationships and the feelings, thoughts, and behaviours related to engaging in these relationships. However, findings by Wiltgen, Arbona, Frankel and Frueh (2015) have shown that attachment avoidance mediated anxiety disorder in a clinical sample of adults with experiences of interpersonal trauma (in adulthood). This overview identified conflicting research findings, and suggested that attachment alone, particularly avoidant attachment, may not fully explain why trauma survivors develop day-to-day difficulties following interpersonal violence.

2.6.4. Conceptual and methodological difficulties of attachment research

There are other issues with research on attachment that are relevant for trauma research. Firstly, Meins (2017) argued that attachment styles have been understood as personality traits of individuals based on the argument that a person’s attachment style is consistent over the life span and, according to Arikan, Stopa, Carnelley,
Karl (2016) and Bowlby (1969, 1982), implies that a person’s attachment style remains relatively constant in adulthood. This would suggest that an insecure attachment style following childhood trauma could not be changed and other factors would need to be considered in recovery from trauma. However, studies have shown that adults displaying insecure attachment in childhood displayed ‘earned’ secure attachment in adulthood (Roisman, Padron, Sroufe, & Egeland, 2002; Saunders, Jacobvitz, Zaccagnino, Beverung, & Hazen, 2011). Rather, attachment might be regarded as a relational and dynamic process, able to change over time. Thus, recovering from trauma may include changing relationship dynamics.

Secondly, research on attachment has employed a range of measurements (e.g., various self-report measures and interviews, observations and assessing participants’ relationship to peers, partners, parents and caregivers) (Meins, 2017). This has made it difficult to compare findings. In particular, these methods were designed to ask participants to think of a specific person or social context so the results may describe selective relationships and not a more general pattern (Meins, 2017). However, it could be argued that trauma survivors may attach securely to one person, attach anxiously to another, and avoid close attachment in a third relationship. Current research appears to have overlooked this possibility.

Thirdly, most of the research has depended on individuals’ retrospective self-report which are prone to response bias (Lilly & Lim, 2013). These reports have assessed how trauma survivors perceived themselves in relationships which may be different to how an observer would view them.

Next, the large body of research on attachment has been retrospective or cross-sectional or has been correlated with other problems (Karantzas et al., 2016; Lilly & Lim, 2013; Meins, 2017). Therefore, it is not possible to determine whether maltreatment causes insecure (anxious) attachment or other factors are operating. Similarly, it is impossible to establish whether insecure (anxious) attachment causes
revictimisation in later life. Only a few empirical and longitudinal studies have sought to establish causality and map attachment patterns over time (Bryant, 2016; Karantzas et al., 2016; Lilly & Lim, 2013; Woodhouse et al., 2015).

Additionally, some research on attachment and trauma has not distinguished between different insecure attachment styles (Karantzas et al., 2016; Yumbul, Cavusoglu, & Geyimci, 2010). However, this is important as each attachment style is characterised by a distinct pattern of engaging with others and the world.

Finally, Meins (2017) argued that insecure attachment has been equated with no attachment or maladaptation. However, other research studies on attachment did not classify individuals as having no attachment, even when children grew up in extremely disruptive circumstances, such as persistent maltreatment or parental substance abuse. Cyr, Euser, Bakermans-Kranenburg and van Ijzendoorn (2010) discussed evidence that 32%-55% of maltreated children and 7%-34% of apparently normal young children displayed insecure or disorganised attachment. While these results suggested that child maltreatment could contribute to insecure attachment, they did not explain why other maltreated children did not develop insecure or disorganised attachment, or why children in relatively secure home environments did develop insecure attachment. However, regarding the latter, Cyr et al. (2010) showed that non-maltreated children may have developed insecure attachment due to increased socioeconomic risks, such as growing up in poverty. Therefore, it could be argued that different attachment styles could be seen as individual differences or as resulting from other environmental factors. Bryant (2016) and Meins (2017) argued that over one third of individuals are insecurely attached and, therefore there is no justification for regarding insecure attachment as pathological or secure attachment as normal. Woodhouse et al. (2015) suggested that avoidant attachment may have some protective attributes. Alternatively, Bryant (2016) proposed that there may be evolutionary advantages in insecure attachment and disadvantages in secure attachment. For instance, the vigilance of individuals with anxious
attachment may increase their ability to detect danger sooner than individuals with secure attachment. Correspondingly, individuals with avoidant attachment may be able to find escape routes that securely attached individuals might not consider. Thus, there may be circumstances where individuals with secure attachment are disadvantaged because they may be inclined to seek social support and be too slow to detect any inherent dangers (Ein-Dor, Mikulincer, Doron, & Shaver, 2010). Further research evidence published by Ein-Dor, Mikulincer, and Shaver (2011) has supported this theory.

Overall, attachment alone cannot explain why some individuals develop trauma-related difficulties and others do not. Therefore, one needs to look for other explanations.

### 2.7. Underlying mechanism II: Resilience, vulnerability and coping

An alternative hypothesis explaining why individuals do not develop trauma responses may be resilience. Resilience has been defined as the ability to continue developing normally despite difficult circumstances (Luthar, Cicchetti, & Becker, 2000; Meins, 2017), to bounce back, and maintain stable functioning after adversity (Bonanno, 2004; Eve & Kangas, 2015; Kaye-Tzadok & Davidson-Arad, 2016; Wood & Bhatnagar, 2015). Burton, Cooper, Feeny, and Zoellner (2015) argued that resilience is not to be confused with stress resistance whereby a person’s functioning is not interrupted by trauma. Instead, “resilience involves a temporary decrease in functioning after a trauma followed by recovery” (Burton et al., 2015, p. 194; Layne et al., 2009; Layne, Warren, Watson, & Shalev, 2007). A lack of resilience (and resistance) would increase vulnerability to persistent distress and malfunctioning.
The advantage of the construct ‘resilience’ is that it not only includes protective factors inherent in the individual but also encompasses external factors as well as complex and dynamic processes. In other words, resilience to trauma – or the lack thereof – takes into account survivors’ personal attributes, their practical and cognitive coping strategies, their emotion regulation skills, neurological factors, physical health, and social functioning, as well as external factors, such as family functioning, social support, type and time of trauma event, and the broader environment at different time points (e.g., Burton et al., 2015; Horn, Charney, & Feder, 2016; Kaye-Tzadok & Davidson-Arad, 2016; Meins, 2017; Wood & Bhatnagar, 2015).

Research has identified a range of protective and risk factors associated with interpersonal trauma and resilience. For example, Banyard, Hamby, and Grych’s (2017) study of a community sample found that victimisation in childhood and current financial problems were risk factors for people’s health, while emotion regulation skills, meaning making, practicing forgiveness, and community and social support were protective factors for their health. There have been mixed findings with regards to social support. On the one hand, there has been evidence for social support having a buffering effect against trauma; while on the other, there has been evidence that social support was not always perceived positively (Burton, 2015). A systematic review by Domhardt et al. (2015) found that education, emotional and interpersonal skills, a sense of control, active coping, positivity, social attachment, external attribution of blame, and family and community support were protective factors for survivors of childhood sexual abuse, while coping by avoiding close relationships was found to be a risk factor.

Yet, some caution needs to be exercised when considering resilience. According to Burton et al. (2015), research on resilience is still in its early stages and requires more cohesion. Meins (2017) argued that there is a lack of agreement about its definition that results in different operationalisations and measurements. There has also been disagreement about whether resilience should be regarded as a personal trait or a
dynamic process (Meins, 2017). Various protective and risk factors have been shown to interact with each other, making it difficult to establish causal links. It is not clear in the first place how many factors and what benchmark to include in this construct (Domhardt et al., 2015). In addition, some literature has regarded resilience as similar to the construct of ‘post-traumatic growth’, while others have viewed them on a continuum or in a hierarchy (Burton et al., 2015; Eve & Kangas, 2015). This inconsistency requires further investigation. Similar to research on attachment, resilience research has been limited to cross-sectional studies, self-report measures and predominantly female samples, and would benefit from longitudinal studies (Domhardt et al., 2015). Nonetheless, because of its holistic approach and the complexity of interpersonal trauma, resilience (or vulnerability due to a lack of resilience) is worth pursuing further.

Three of these resilience factors are now explored in more detail. These are: cognitive coping, emotion-focused coping, and interpersonal coping. Cognitive coping has been studied most widely. Emotional and interpersonal coping strategies are worthy of attention because emotion dysregulation and interpersonal difficulties have been documented as two key difficulties among trauma survivors (Charuvastra & Cloitre, 2008; Cloitre et al., 2005; Courtois, 2004; Ehring & Quack, 2010; van der Kolk et al., 2005).

2.7.1. Cognitive coping

The cognitive model of PTSD by Ehlers and Clark (2000) postulated that trauma survivors (1) appraise the traumatic event or its consequences as extremely negative and (2) have difficulties elaborating and contextualising traumatic experiences and continue associating present experiences with memories of previous trauma. As a result, they suggested trauma survivors may experience ongoing external or internal threats, such as ‘the world is a dangerous place’ and ‘I am unable to cope’.
Research evidence has confirmed that exposure to interpersonal trauma is associated with negative cognition about the world, self and others and predicts various psychopathologies (e.g., Beck et al., 2015; Conway, Starr, Espejo, Brennan, & Hammen, 2016; Lilly & Lim, 2013). For instance, Barlow et al.’s (2017) study showed that exposure to child abuse was associated with negative trauma appraisal and PTSD symptoms in a student sample. In a meta-analysis, Mitchell, Brennan, Curran, Hanna, and Dyer (2017) found a strong association between cognitive trauma appraisal and post-traumatic symptoms in children and adolescents. Ogle, Rubin, and Siegler (2016) found that when traumatic events (interpersonal and non-interpersonal) were perceived as more central to one’s identity and as severe then older adults with anxious attachment styles reported greater PTSD severity.

Negative post-traumatic self-cognition has been found to predict greater post-traumatic stress in a university staff and student population (Arikan et al., 2016). Also, early emotional abuse (but not general trauma or physical or sexual abuse) was associated with reported metacognitive beliefs (such as ‘Worrying helps me to avoid problems in the future’ or ‘It is bad to think certain thoughts’) in a sample of university staff and students (Myers & Wells, 2015). Held, Owens, and Anderson (2015) found that trauma-related guilt – a form of negative cognition whereby one blames and criticises oneself – was associated with PTSD severity. Interestingly, guilt and shame in this study also predicted disengagement and avoidant coping.

Cognitive coping by avoidance has been linked to negative outcomes. For example, cognitive avoidance, experiential avoidance or thought suppression has been associated with PTSD severity and distress intolerance (Burton et al., 2015; Chesney & Gordon, 2017; meta-analyses by Naragon-Gainey, McMahon, & Chacko, 2017; Seligowski et al., 2015). Avoidant coping also predicted non-resilience (Domhardt et al., 2015). Other forms of cognitive coping after trauma are rumination – an excessive repetitive thinking about stressful events and their causes and consequences – and worrying – a negative repetitive thinking about future events.
(Naragon-Gainey et al., 2017). Again, research evidence has established relationships between rumination or worry and PTSD severity (e.g., Chesney & Gordon, 2017; Naragon-Gainey et al., 2017; Seligowski et al., 2015).

In contrast, there is evidence that positive appraisal (also ‘cognitive processing’, ‘cognitive reappraisal’ or ‘meaning making’) lowers PTSD symptoms, and strengthens resilience or post-traumatic growth. Reappraisal implies a change in one’s perspective or interpretation of events, and this thinking differently alters one’s response (Naragon-Gainey et al., 2017; Seligowski et al., 2015). Indeed, a meta-analysis by Seligowski et al. (2015) found no significant association between reappraisal and PTSD. Also, high cognitive reappraisal and low suppression have been associated with the lowest level of post-traumatic stress (Eftekhari, Zoellner, & Vigil, 2009). Self-esteem (that is, being able to think well of oneself) has been associated with subjective health in female adult survivors of child sexual abuse (Domhardt et al., 2015). Self-esteem and positive reframing have been linked to post-traumatic growth (Helgeson, Reynolds, & Tomich, 2006; Linley & Joseph, 2004).

However, other researchers have published conflicting findings. For example, negative cognitive appraisal does not fully account for the person developing PTSD, suggesting that there are other factors involved. Equally, not all individuals exposed to interpersonal traumatic events develop cognitive biases (to the same degree). What is more, cognitive coping strategies that have been related to negative outcomes (e.g., rumination, negative cognitive appraisal, thought suppression) are not always maladaptive; while strategies that have been related to positive outcomes (e.g., reappraisal) may not always be adaptive. For instance, Naragon-Gainey et al. (2017), Grych, Hamby, and Banyard (2015) and Foster et al. (2015) suggested that in some circumstances avoidant coping can be a safer and more productive response. Similarly, Joseph et al. (2012) argued that cognitive appraisal can be both adaptive and maladaptive; maladaptive in the form of rumination, and adaptive in the form of reflective pondering.
Similar problems can be identified in research on cognitive coping as with research on attachment and resilience. Firstly, multiple concepts of cognitive coping after traumatic life experiences have not been clearly defined and, thus, it is difficult to determine if they refer to the same constructs or to different constructs with overlapping aspects. For example, it is unclear as to whether biased perception or biased cognition of stress (Conway et al., 2016) are the same concept as or different from trauma appraisal (Barlow et al., 2017; Mitchell et al., 2017) or negative cognitive appraisal (Barlow et al., 2017) or negative post-traumatic self-cognition (Arikan et al., 2016). Similarly, it is ambiguous as to whether cognitive reappraisal is the same as or different from post-traumatic growth, cognitive processing, or meaning making or trauma-related coping self-efficacy (Bosmans, van der Knaap, & van der Velden, 2016; Eve & Kangas, 2015; Ulloa, Guzman, Salazar, & Cala, 2016).

Secondly, assessments of cognitive coping have been based on retrospective self-reports and, therefore, have relied on participants accurately recalling their experiences and accurately evaluating themselves (e.g., Lilly & Lim, 2013). A large number of studies looking for correlations between these various cognitive responses and outcomes have not been able to determine cause and effect. There has also been a lack of longitudinal studies. Joseph et al. (2012), for instance, suggested that it would be valuable to investigate changes in appraisal over time.

Thirdly, a dominant focus on cognitive coping among trauma survivors has neglected evaluations of contributory external factors. Burton et al. (2015, p. 200), for example, argued that our beliefs “provide the perspective through which we interpret significant events in our lives [and these] are guided and informed by our cultural background”. In this respect, a qualitative study by Foster et al. (2015) found that the context of intimate partner violence influenced coping strategies. The inclusion of social and environmental factors in research on cognitive coping after trauma may also challenge current evidence which has shown a binary division
between some strategies considered as adaptive and others as being maladaptive (Foster et al., 2015; Grych et al., 2015).

2.7.2. Emotion-focused coping and emotion regulation difficulties

Cognitive coping has been found to correlate strongly with the regulation of emotions (Barlow et al., 2017). Several cognitive coping strategies have been assessed frequently as part of the ‘emotion regulation’ construct (e.g., reappraisal, thought suppression, experiential avoidance, rumination, worry). While disagreements about the definition of emotion regulation persist, the concept can be broadly defined as a process by which feelings are monitored, evaluated and altered to reach a certain goal (Naragon-Gainey et al., 2017; Séguin-Lemire et al., 2017). Emotion regulation skills are characterised by an awareness of one’s own and other people’s emotions, goal-directed behaviour when experiencing unwanted feelings, and using appropriate emotion regulation strategies depending on situational demands (Gratz & Roemer, 2004; Gross, 2013). By contrast, dysregulation of emotions is characterised by unstable or impulsive emotional reactions, and on excessive control or a lack of control over feelings (Séguin-Lemire et al., 2017). Research on emotion regulation has commonly used Gratz and Roemer’s (2004) four dimensions which assess (1) the lack of awareness and clarity of emotions, (2) difficulties accepting negative emotions, (3) difficulties with goal-directed behaviour and impulse control following negative emotions, and (4) lack of ability to access appropriate regulation strategies. Most existing research has focused on how negative emotions can be reduced.

Heightened emotional reactions as well as emotion dysregulation have been reported as a core problem in individuals affected by interpersonal trauma experiences (e.g., Cloitre et al., 2011; Ford et al., 2005; van der Kolk, 1996).
**Evidence of emotional reactivity**

With regards to emotional reactivity, research has reported that trauma survivors commonly show strong feelings of fear, terror and helplessness as well as shame, guilt, anger, mistrust, and disgust (American Psychiatric Association, 2007; Badour et al., 2017; Berthelot et al., 2014; Coyle, Karatzias, Summers, & Power, 2014; Kim, Talbot, & Cicchetti, 2009; Power & Fyvie, 2013). For example, Badour et al. (2017) found that, in a national population of adults with history of interpersonal trauma, individuals scoring high on fear were 1.86 times more likely to develop PTSD, individuals scoring high on anger were 4.98 times more likely, and individuals scoring high on shame were 2.33 times more likely to go on to PTSD. This study also found a gender difference whereby women experienced more intense feelings after interpersonal trauma than men. Coyle et al. (2014) showed that fear predicted distress and symptoms of re-experiencing the traumatic events in a population of survivors of childhood sexual abuse. They also reported higher rates of disgust and lower rates of happiness among this group. Higher levels of fear of emotions in survivors of child abuse have also been reported by Tull, Jakupcak, McFadden, and Roemer (2007), and this fear of feelings predicted severity of PTSD. Robinaugh and McNally (2010) demonstrated that the common feeling of shame among survivors predicted symptoms of PTSD and depression. Evidently, anxiety – although considered the key emotion in PTSD – is not the only heightened emotion experienced by trauma survivors. In fact, Powers and Fyvie (2013) found in a preliminary study that more than 50% of trauma survivors presented with primary emotions other than anxiety. Caution also needs to be exercised not to confuse emotional reactivity with emotion regulation (Aldao, Gee, De Los Reyes, & Seager, 2016; Seligowski et al., 2015).

**Evidence of emotion regulation difficulties**

There is ample evidence that trauma survivors are affected by difficulties in managing their intense feelings. Some of this evidence has examined emotion regulation difficulties more generally, and other evidence has examined specific emotion regulation strategies in connection with interpersonal violence exposure or post-traumatic stress.
Research on general emotion regulation has shown that maternal emotional abuse and childhood sexual abuse were positively associated with affect regulation and tension reduction activities, while low paternal emotional support was negatively associated with tension reduction behaviour in the general population (Briere & Rickards, 2007). Childhood physical abuse, non-interpersonal traumas and trauma in adulthood were unrelated to several self-regulation scales in this study. By contrast, Jennissen et al. (2016) found that all types of childhood maltreatment were related to emotion regulation difficulties, and that these difficulties were strongly associated with developing mental health problems. Further evidence has strengthened the relationship between early maltreatment and general emotion regulation difficulties, and between general emotion regulation difficulties and day-to-day difficulties in adulthood (Barlow et al., 2017; Liu, Schulz, & Waldinger, 2015; Powers, Etkin, Gyurak, Bradley, & Jovanovic, 2015; Séguin-Lemire et al., 2017; Seligowski et al., 2015; Sheynin & Liberzon, 2017; Stevens et al., 2013; Zamir & Lavee, 2016). These findings supported the concept that emotion regulation difficulties might be unique to childhood maltreatment compared with other types of traumatic events. This may be partially true: Ehring and Quack (2010) found that all assessed variables of emotion dysregulation were significantly associated with post-traumatic stress severity regardless of trauma type (i.e., childhood single interpersonal trauma, childhood ongoing interpersonal trauma, adult trauma, non-interpersonal trauma, and adult interpersonal trauma). However, adult survivors of ongoing interpersonal trauma in childhood reported greater dysregulation than adult survivors of single traumatic events in childhood or traumatic events in adulthood and, in particular, a lack of clarity of emotions and difficulties engaging in goal-directed behaviours. Conversely, better general emotion regulation contributed to better physical health after victimisation in childhood in an adult community sample (Banyard et al., 2017).

Other researchers have begun to examine specific emotion regulation strategies and their impact on developing psychopathologies after exposure to traumatic events.
Common strategies previously investigated were acceptance of emotions, behavioural and experiential avoidance, distraction, expressive suppression, mindfulness, problem solving, rumination, reappraisal and worry (meta-analysis by Naragon-Gainey et al., 2017). For example, there has been evidence of high levels of suppression but low levels of reappraisal predicting post-traumatic stress (Barlow et al., 2017; Eftekhari et al., 2009; Larsen & Berenbaum, 2015; Sheynin & Liberzon, 2017). However, a thorough systematic review has shown a more nuanced picture: Naragon-Gainey et al.’s (2017) meta-analysis has associated distress tolerance with low levels of worry (rs = –0.57), experiential avoidance (rs = –0.54), and rumination (rs = –0.28), and with moderately high levels of mindfulness (rs = 0.38), and accepting emotions (rs = 0.34). Distress tolerance showed only small, yet significant, correlations with expressive suppression, problem-solving and reappraisal. Another meta-analysis has reported that rumination, thought suppression and experiential avoidance were most strongly and positively associated with PTSD; expressive suppression and worry were moderately and positively associated with PTSD; while acceptance and reappraisal were not significantly associated with PTSD (Seligowski et al., 2015). Differences among these studies might be explained by including different samples (e.g., community, undergraduates, or females) or trauma types. Table 2 shows a summary of these studies.

Table 2

Emotion regulation strategies reported as relating and not relating to PTSD or distress intolerance

<table>
<thead>
<tr>
<th>Authors</th>
<th>High levels associated with PTSD or distress intolerance</th>
<th>Low levels associated with PTSD or distress intolerance</th>
<th>Not associated with PTSD, or associated with distress tolerance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barlow et al. (2017); Eftekhari et al. (2009); Sheynin &amp; Liberzon (2016)</td>
<td>suppression</td>
<td>reappraisal</td>
<td></td>
</tr>
<tr>
<td>Authors</td>
<td>High levels associated with PTSD or distress intolerance</td>
<td>Low levels associated with PTSD or distress intolerance</td>
<td>Not associated with PTSD, or associated with distress tolerance</td>
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<tr>
<td>-------------------------------</td>
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<td>--------------------------------------------------------</td>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>Larsen &amp; Berenbaum (2015)</td>
<td>suppression</td>
<td>mindfulness, rumination, accepting emotions</td>
<td>expressive suppression, problem-solving, reappraisal</td>
</tr>
<tr>
<td>Naragon-Gainey et al. (2017)</td>
<td>worry, experiential avoidance</td>
<td>mindfulness, rumination, accepting emotions</td>
<td>expressive suppression, problem-solving, reappraisal</td>
</tr>
<tr>
<td>Seligowski et al. (2015)</td>
<td>rumination, thought suppression, experiential avoidance</td>
<td>expression, worry, acceptance, reappraisal</td>
<td></td>
</tr>
</tbody>
</table>

The variability with which emotion regulation strategies best predict PTSD persists in other more recent research. For instance, Jennissen et al. (2016) found that limited access to emotion regulation strategies predicted psychopathology the most, while lack of awareness predicted psychopathology the least. Lilly and London (2015) found that non-acceptance and impulsivity to be highly predictive of multiple psychopathology in female survivors of interpersonal trauma (including childhood and adulthood, and single and ongoing traumatic life events; but excluding neglect and emotional abuse). Jardin, Sharp, Garey, and Zvolensky (2017) found that negative affect combined with impulsivity was associated with risky sexual behaviour in young adults, suggesting that such behaviour may function to reduce negative feelings.

Conflicting evidence has been reported by Chesney and Gordon (2017): Some studies indicated a negative relationship between reappraisal and post-traumatic stress, and other studies reported no significant relationship. Some studies showed a
positive relationship between suppression or avoidance and post-traumatic stress, but others found no such association. While some studies found that frequent exposure to traumatic events predicted a specific emotion dysregulation profile, others did not. Some of these differences may be due to varying characteristics in the research sample, assessed trauma types, or measurements used. In addition, post-traumatic stress symptom clusters might manifest in different ways in interpersonal trauma survivors, and clusters might be uniquely related to specific emotion regulation strategies. Short, Norr, Mathes, Oglesby, and Schmidt (2016), for example, showed that difficulties in accessing appropriate emotion regulation strategies and in emotional clarity were related to numbing, while difficulties in impulse control consistently related to all PTSD clusters. Emotion regulation facets of non-acceptance and difficulties engaging in goal-directed behaviour were unrelated to symptom clusters of post-traumatic stress. However, this study did not distinguish between interpersonal and non-interpersonal trauma exposure, and traumatic events in childhood or adulthood.

Conceptual and methodological difficulties of emotion regulation
This review of the emotion regulation literature has identified several problems. Four conceptual issues are discussed next. Firstly, Aldao et al. (2016) argued that emotion regulation has been viewed as static; however, it is a dynamic process. That is, while effective regulation may be a protective factor and dysregulation may be a risk factor for mental health difficulties, those problems may impact on emotion regulation in turn and also be an outcome of other, concomitant factors. Secondly, Naragon-Gainey et al. (2017) argued that studies have investigated cognitive-based strategies of emotion regulation, rather than behavioural strategies, thus conceptualising it largely as cognitive-emotional. Also, relational strategies used to regulate emotions have been assessed as part of different concepts, such as social support, and not as part of emotion regulation. Similarly, few studies have investigated positive emotion regulation strategies and the regulation of positive emotions. Thirdly, Seligowski et al. (2015) noted that there is considerable overlap in
constructs of emotion regulation strategies. For example, thought suppression and experiential avoidance both refer to a disengagement from internal experiences. Rumination and worry both refer to excessive negative thinking in a passive manner. Equally, some facets of emotion regulation overlap with post-traumatic symptoms and other psychiatric disorders (e.g., impulsivity is associated with hyperarousal criteria in PTSD) (Ehring & Quack, 2010; Seligowski et al., 2015). Consequently, studies risk trying to assess aspects that are alike to a certain degree but fail to investigate their distinctive differences. Finally, specific emotion regulation strategies have been categorised into either adaptive or maladaptive strategies based on whether that strategy has been significantly associated with PTSD or other difficulties. While this approach is valuable in developing tailored interventions, such an understanding may be too narrow (Aldao et al., 2016; Naragon-Gainey et al., 2017). Emotion regulation appears to be more complex. For example, research evidence has been inconsistent with regards to which emotion regulation strategies are adaptive and which are maladaptive (e.g., Chesney & Gordon, 2017). This may be due to the differing characteristics of the samples, external factors or the use of different measures. Also, where specific strategies accounted for psychopathology or were unrelated to psychopathology, this did not apply to all cases in those samples. This suggests that not every individual finds putative maladaptive strategies problematic or putative adaptive strategies beneficial. Lastly, Naragon-Gainey et al. (2017) suggested that emotion regulation strategies can be adaptive in one situation and maladaptive in another.

In addition, there are several methodological challenges. Firstly, studies differed in the type of traumatic events and the traumatised population they assessed (Aldao et al., 2016). For instance, where only a relationship between emotion regulation and post-traumatic stress was assessed – ignoring the type of trauma incident – these studies could not determine nuances in this relationship (as in Seligowski et al.’s (2015) meta-analysis). In other studies, only childhood maltreatment (without comparison to assault in adulthood or non-interpersonal traumatic incidents) or
only interpersonal traumatic events (without comparison to non-interpersonal traumatic events) were examined in terms of emotion regulation and post-traumatic stress (e.g., Briere & Rickards, 2007). By contrast, Ehring and Quack’s (2010) study has provided a valuable comparison of trauma types.

Secondly, Naragon-Gainey et al. (2017) criticised the lack of knowledge about how emotion regulation strategies are employed in day-to-day life as opposed to habitually. Instead, the majority of the studies have relied on ratings of participants’ perceptions. In other words, findings have depended on retrospective self-reports, cross-sectional designs, female participants, student populations, and samples drawn from populations without documented pathology (e.g., Aldao et al., 2016; Barlow et al., 2017; Beck et al., 2015; Bennett, Modrowski, Chaplo, & Kerig, 2016; Briere & Rickards, 2007; Chesney & Gordon, 2017; Jennissen et al., 2016; Lee, Witte, Weathers, & Davis, 2015; Lilly & Lim, 2013; Naragon-Gainey et al., 2017; Seligowski et al., 2015). Therefore, Bennet et al. (2016) suggested using different methods and informants when investigating emotion regulation and its relationship to PTSD.

The reliance on these limited study designs means there is a lack of robust experimental, longitudinal and prospective studies that could determine cause and effect between emotion regulation and post-traumatic stress (e.g., Barlow et al., 2017; Beck et al., 2015; Bennett et al., 2016; Briere & Rickards, 2007; Ehring & Quack, 2010; Jennissen et al., 2016; Lilly & Lim, 2013; Naragon-Gainey et al., 2017; Seligowski et al., 2015). Power et al. (2015) was one of the few experimental studies reviewed here, while Séguin-Lemire et al. (2017) was one of only a small number of longitudinal studies. It is the case that several neurological, biological and physiological studies have examined emotion regulation in relation to stress and PTSD (Aldao et al., 2016; Dayan, Rauchs, & Guillery-Girard, 2017; Marusak, Martin, Etkin, & Thomason, 2015; McLaughlin, Peverill, Gold, Alves, & Sheridan, 2015; Moser et al., 2015; Nicholson et al., 2017; Sheynin & Liberzon, 2017; Stark et al., 2015) and have yielded further insights into causality. In particular Nicholson et al.’s
(2017) study has shown that providing real-time fMRI neurofeedback to patients with PTSD down-regulated their amygdala activity and they were able to sustain this downregulation in subsequent tasks without neurofeedback.

As a result of these multiple conceptual and methodological shortcomings, research on emotion regulation has placed trauma survivors at the centre of understanding regulatory deficits, thus regarding emotion regulation as intrapsychic problem that needs repairing. This might have serious implications because the responsibility for not managing distress could be too readily attributed to the individual alone, while the impact of a malfunctioning environment might be overlooked. In other words, research on emotion regulation has largely disregarded the impact of specific factors or processes resulting from an abusive or neglectful environment on adult trauma survivors’ difficulties (or perhaps their ability) to manage distress. Likewise, the impact of a favourable environment on trauma survivors’ ability to manage distress is still poorly understood.

2.7.3. Interpersonal coping and difficulties

Interpersonal violence, subsequent post-traumatic stress, cognitive trauma appraisals, and emotion dysregulation can all impact on the way survivors relate to others. Several studies of interpersonal trauma have assessed interpersonal difficulties more broadly. For example, Cloitre et al.’s (2005) study found interpersonal problems to be a strong predictor of functional impairment (e.g., performance at work, in leisure activities, within family and relationships, and as parent) in women with child physical and/or sexual abuse histories. Here, interpersonal functioning was assessed using the Inventory of Interpersonal Problems and referred to a person’s assertiveness, sociability, intimacy, submissiveness, responsibility, and control. Functional impairment was also assessed using a self-report questionnaire (i.e., Social Adjustment Scale Self-Report).
Briere and Rickards (2007) reported that maternal emotional abuse was associated with interpersonal conflicts (i.e., finding it difficult to maintain important relationships), abandonment concerns (i.e., worrying about being rejected by others), and susceptibility to influence (i.e., being vulnerable and compliant to direction and control from others), and that low paternal emotional support was associated with interpersonal conflicts and abandonment concerns in the general population. While these studies attempted to explore a wide range of interpersonal functioning, the majority of research into interpersonal trauma has focused on specific interpersonal coping strategies, specific interpersonal circumstances, or social support.

**Specific interpersonal coping strategies**

Specific interpersonal coping strategies include avoiding others, becoming over-dependent on others or hostile towards them, and mistrusting others. There has been evidence that trauma survivors isolate themselves from others and frequently rely on themselves (e.g., Bermudez et al., 2013; Charuvastra & Cloitre, 2008; Chouliara et al., 2014; Cloitre et al., 2009, 2010, 2011; Markowitz et al., 2009). Bermudez et al. (2013) reported that, when individuals do socialise, this is accompanied by discomfort. There has also been evidence that trauma survivors can become over-reliant on others (Cloitre et al., 2009), preoccupied with relationships (Cloitre et al., 2011), and over-controlling and overprotective of other people (Chouliara et al., 2014; Kim et al., 2009). Other studies have shown increased anger and subsequent aggressive behaviour towards others in interpersonal trauma survivors (Birkley, Eckhardt, & Dykstra, 2016; Maercker & Hecker, 2016). In this respect, Bermudez et al. (2013) highlighted that, instead of expressing their needs constructively, trauma survivors might adopt a destructive and hostile communication style.

Furthermore, interpersonal difficulties among trauma survivors have been frequently associated with difficulties in trusting others (e.g., Fertuck et al., 2016; Gobin & Freyd,
2014; Markowitz et al., 2009), although focused research on mistrust and interpersonal trauma has been limited. Crawford and Wright (2007) reported that a history of childhood maltreatment, aggravated by interpersonal difficulties such as mistrust, contributed to intimate partner violence. Similarly, Lutz-Zois, Phelps, and Reichle (2011) found that female survivors of childhood sexual abuse were more likely to be exposed to adult sexual abuse due to higher levels of mistrust of others compared to females without exposure to childhood sexual abuse. These authors highlighted a paradox: Why would greater mistrust of others – which may lead to protecting oneself from further harm – result in higher levels of revictimisation? They proposed that when trauma survivors do not trust people in general then the concept of trust becomes meaningless and, consequently, this makes it difficult for them to distinguish between trustworthy safe people and unsafe people.

**Coping in specific interpersonal circumstances**

Research has established that there are various difficulties in intimate relationships associated with trauma symptoms or previous abuse. There has been evidence to suggest that trauma survivors find it more difficult to establish lasting and satisfying intimate relationships (e.g., Godbout et al., 2013; Pearlman & Courtois, 2005). Different results according to gender have been reported by DiLillo et al. (2009). In a sample of newlywed couples with histories of child abuse and neglect, they found lower levels of marital satisfaction for husbands who had experienced physical or psychological abuse or neglect, but the wives reported lower satisfaction only when they had experienced childhood neglect.

Evidence has been widely reported regarding increased conflict in relationships. For instance, Kim et al. (2009) found that shame was associated with increased conflict in intimate adult relationships among women with childhood sexual abuse. Similarly, women with a history of childhood emotional abuse displayed poorer couple adjustment and greater conflicts in their relationships which has been linked to lack of interpersonal skills (Bigras et al., 2015). Low levels of emotional support
from a father and emotional abuse from a mother in childhood were associated with higher levels of interpersonal conflict in adulthood (Briere & Rickards, 2007). Owen, Quirk, and Manthos (2012) found that young adults with experiences of betrayal trauma reported a perceived lack of respect from their partner.

In some cases, increased relationship conflict may escalate to relationship victimisation. For example, intimate partner violence later in life among women exposed to childhood maltreatment was reported by Browne et al. (1986), Godbout et al. (2017), Stevens et al. (2013), and Zamir and Lavee (2016). Similarly, Dietrich (2007) showed that difficulties with interpersonal relatedness among women with a history of child maltreatment predicted physical and sexual revictimisation by a partner or non-partner in adulthood. Lang, Stein, Kennedy, and Foy (2004) showed that significantly impaired negotiation in relationships, and significantly higher levels of psychological aggression, physical assault, sexual coercion and injuries contributed to intimate partner violence. A sense of self-sacrifice has been shown to predict intimate partner violence in adulthood after exposure to psychological child maltreatment (Crawford & Wright, 2007).

In addition, some research has reported parenting difficulties among trauma survivors with children (e.g., Briere & Rickards, 2007; Vaillancourt et al., 2017). Van Ee et al. (2016) found parents with post-traumatic stress symptoms to be less emotionally available to their children and to view their children more negatively than parents without PTSD symptoms. Though, this study included exposure to any traumatic event without distinguishing between interpersonal and non-interpersonal trauma experiences. Similarly, Pinto, Correia-Santos, Levendosky, and Jongenelen (2016) reported that post-traumatic stress in mothers who had experienced intimate partner violence was associated with low maternal satisfaction and high parenting stress. Difficulties with parenting may disrupt a child’s development and set in motion a generational cycle of disrupted attachment, and deficits in emotion regulation, interpersonal skills and identity formation (e.g., Gee
& Casey, 2015; Katz & Gurtovenko, 2015; van Ee et al., 2016). Notably, studies on parenting difficulties have relied on only small to medium sample sizes, convenience sampling, and a fundamental difference in research on mothers and fathers (van Ee et al., 2015). In this regard, van Ee et al. (2015) observed that parenting research has studied the perceived parent-child relationship or perceived child difficulties via parent ratings in male-dominated samples, while it has studied the observed parent-child relationship or observed child difficulties via researcher observations in female-dominated samples. Thus, research in this area requires improvements to ensure there is more consistent and reliable data collection.

**Social support**

Relational difficulties may not only originate from the troubled individual, but also from external factors, such as the level and quality of social support. Evidence on the effects of social support is varied (Bryant, 2016; Charuvastra & Cloitre, 2008). Generally, absent or negative social support has been linked to higher levels of post-traumatic stress. For example, two meta-analysis demonstrated that lack of or poorer social support were a high-risk factor for PTSD severity (Brewin, Andrews, & Valentine, 2000; Ozer et al., 2003). Other studies found lower social support to be a factor that increases the association between child abuse and post-traumatic stress symptoms (e.g., Stevens et al., 2013). Also, Charuvastra and Cloitre (2008), Dorahy et al., (2009), Markowitz et al. (2009), and Sigurvinsdottir and Ullman (2015) discussed evidence showing that negative responses from the person’s community impact on his or her recovery process. For instance, exclusion, stigmatisation and limited social support from others may cause the traumatised individual to avoid interactions with their community. Similarly, Chouliara et al. (2014) presented evidence that unsupportive responses to trauma disclosure as well as secrecy, particularly in the family, hindered the recovery process. Weiss, Garvert, and Cloitre (2015) compared sexual minority women (bisexual, lesbian, and other) with heterosexual women, each group having been exposed to interpersonal violence and having a diagnosis of PTSD. They found a greater negative impact on the functional
impairment of minority group women who lacked social support. However, these studies have not explained whether post-traumatic stress resulted in less positive social support, or less positive social support led to the development of post-traumatic stress.

By contrast, positive social support has been linked predominantly to positive health outcomes with the exception of a few cases showing no association between positive social support and PTSD (e.g., reviews by Bryant, 2016; Charuvastra & Cloitre, 2008; Domhardt et al., 2015; Elderton, Berry, & Chan, 2017). For instance, higher levels of social support were associated with lower PTSD severity in studies where PTSD was assessed more than three years after the traumatic event, and in studies of combat trauma than in studies of interpersonal violence (Ozer et al., 2003). Charuvastra and Cloitre (2008) have distinguished functional (perceived) from structural (actual) social support and suggested that perceiving support from others as helpful was more predictive of positive mental health outcomes than measuring external aspects of a person’s social network. Other studies have shown temporal changes in social support related to PTSD (e.g., Maercker & Hecker, 2016). It has been suggested that positive social support reduces activity of the hypothalamic-pituitary-adrenal (HPA) stress system, thus reducing stress responses (Hostinar, Johnson, & Gunnar, 2015; Maercker & Hecker, 2016). Therefore, social support acts as an emotion regulator. Anderson, Renner, and Danis (2012, p. 1291) also found that positive support received from family and employers after experiences of domestic violence enabled women “to take action in their lives as their informal network was available to ease their burdens”.

**Conceptual and methodological difficulties of emotion regulation research**

There are several concerns with the quality of the evidence on the interpersonal coping of trauma survivors. Firstly, the majority of studies have investigated specific aspects of interpersonal difficulties (such as aggression, mistrust, revictimisation, and parenting), but have rarely investigated these collectively. It
appears that interpersonal difficulties are not as clearly conceptualised as emotion regulation difficulties. In other words, there is no consensus as to what constitutes interpersonal difficulties so the current selective evidence base has limited our understanding of the full range of adult survivors’ interpersonal coping strategies.

Secondly, research on interpersonal difficulties among trauma survivors does not always distinguish trauma types. Therefore, a conclusion cannot be drawn as to whether specific interpersonal coping strategies are unique to trauma survivors of child maltreatment, intimate partner violence, combat experiences, or non-interpersonal traumatic events. It is unclear whether they are specifically linked to PTSD symptoms or to the experience of significant abuse. Since differences do exist for emotion-focused coping depending on the type of traumatic event, future research should consider that there might also be differences in interpersonal coping resulting from exposure to specific trauma types.

Thirdly, most findings are based on retrospective self-reports and cross-sectional studies, lacking prospective, experiential and longitudinal methods that could establish causality (Birkley et al., 2016; Brewin et al., 2000; Charuvastra & Cloitre, 2008; Cloitre et al., 2005; Owen et al., 2012).

Last but not least, the same shortcoming exists for interpersonal difficulties as has been identified for negative cognitive appraisals and emotion dysregulation, namely that research on interpersonal coping places trauma survivors at the centre of understanding their relational difficulties, thus regarding it as intrapsychic problem that needs repairing. With the exception of research on social support, studies have largely disregarded the impact of context, society, institutions, culture, and other environmental factors. (Maercker & Hecker, 2016; Maercker & Horn, 2013).
2.8. **Interventions to address interpersonal trauma**

These cognitive, emotion regulation and interpersonal difficulties have been addressed using various therapeutic approaches aimed at helping trauma survivors with their recovery. This section evaluates the effectiveness of treatment in terms of trauma symptom reduction, emotion regulation, and improved interpersonal skills and relationships.

2.8.1. **Conventional trauma treatment**

Conventional treatment approaches for trauma (diagnosed as PTSD) include cognitive-behavioural practices (e.g., cognitive-behavioural therapy (CBT), cognitive restructuring, and prolonged exposure), cognitive processing therapy (CPT) and eye movement desensitisation and reprocessing treatment (EMDR). Empirical evidence has demonstrated their effectiveness in reducing PTSD symptoms (Briere & Scott, 2015; Cloitre et al., 2010; Courtois, 2004; Krupnick et al., 2008; van Dam, Vedel, Ehring, & Emmelkamp, 2012). Bisson et al. (2007) conducted a systematic review of 38 randomised controlled trials of trauma-focused CBT, EMDR, stress management and group CBT. This meta-analysis found that these approaches decreased PTSD symptoms compared to a waiting list and treatment as usual, and that trauma-focused CBT and EMDR were equally efficient but more effective than other therapies. Trauma-focused CBT achieved an effect size of -1.70 compared to control groups, EMDR treatment achieved an effect size of -1.54 compared to control groups, other modalities achieved effect sizes between -0.43 and -1.14 compared to control groups or between -0.27 and -0.81 when compared to either trauma-focused CBT or EMDR (an effect size of -0.8 or lower was regarded as meaningful).

According to Ehlers et al. (2010), seven other systematic reviews and meta-analyses found evidence for trauma-focused CBT and EMDR to be effective in reducing PTSD. However, these studies did not distinguish between PTSD derived from...
interpersonal trauma and PTSD derived from non-interpersonal trauma. A subsequent meta-analysis by Ehring et al. (2014) has evaluated the effectiveness of a range of psychological interventions specifically for reducing PTSD in adult survivors of childhood maltreatment. This meta-analysis confirmed earlier results that trauma-focused treatments (trauma-focused CBT, CPT, EMDR) are more effective than non-trauma-focused treatment (CBT, interpersonal, and emotion-focused), while any treatment is more effective than wait list or control conditions. International treatment guidelines have adopted this evidence and recommend trauma-focused therapies as first line treatment (Ehlers et al., 2010; Foa, 2009; NICE, 2005, update from 2014).

Despite this evidence base, several concerns have been raised about these therapeutic approaches. Firstly, Bisson et al. (2007), Cloitre et al. (2010, 2011), Courtois (2004, 2014), and Pradhan, Kluewer D’Amico, Makani, and Parikh (2016) argued that exposure may potentially be harmful unless the client has established personal safety and daily life competencies. For example, Becker, Zayfert, and Anderson (2004) showed that clinicians reported having concerns about increased arousal, re-experiencing symptoms, dissociation, substance misuse, suicide risk, self-injury, and therapy drop-out after patients had been exposed to trauma memories as part of their treatment. There is further evidence from research based on reported drop-out rates and the incidence of PTSD worsening after exposure therapy. For instance, Cloitre et al. (2010) reported a 39.4% dropout rate for exposure treatment compared to 26.3% for emotion and interpersonal skills training only, and a lower dropout rate of 15.2% when exposure treatment was combined with emotional and interpersonal skills training. Similarly, PTSD having worsened at after 6 months’ post-treatment was reported in 31.3% of participants in the exposure group, 22.7% of participants in the emotional and interpersonal skills training group, and no participant in the combined group.
However, Cloitre et al. (2010) also discussed evidence suggesting that empirical findings are limited and inconsistent with regards to exposure therapy being harmful. Evaluations of trauma-focused CBT or EMDR, and non-trauma-focused treatments (e.g., emotion-focused or interpersonal-focused treatment), Ehring et al. (2014) found only a small difference in dropout rates – 23.92% for trauma-focused and 18.51% for non-trauma-focused treatments aimed at interpersonal trauma survivors. Bisson et al. (2007) noted that in some reviewed studies, dropout rates were similar for both trauma-focused treatment and waiting list, and suggesting that perhaps passage of time and ongoing emotional commitments regardless of treatment modality might be challenging for trauma patients. In a meta-analysis, Imel, Laska, Jakupcak, and Simpson (2013) found no systematic difference between interventions for treating PTSD (e.g., prolonged exposure, CPT, EMDR). It is important to note that investigations of dropout rates are problematic because multiple definitions of ‘dropout’ have been used when comparing studies, and because treatment length, study protocols, and characteristics of participants differed. Dropout cases could perhaps also be viewed as ‘early completers’ (Imel et al., 2013). Additionally, Najavits (2015) suggested that dropout rates in real-world practice may be higher than indicated by research evidence based on randomised controlled trials characterised by stricter study conditions.

Secondly, some patients may decline exposure-based therapies because they choose not to address feelings and memories of anxiety (Markowitz et al., 2009). Thirdly, many studies have not assessed whether treatment itself contributed to negative outcomes (Bisson et al., 2007). Finally, while modifying beliefs is fundamental to treating PTSD and building resilience (Burton et al., 2015), it has been suggested that CBT-based approaches alone might not sufficiently address interpersonal and emotion regulation difficulties (Bryant, 2010; Cloitre et al., 2010; Markowitz et al., 2009). This is supported by the notion that traditional PTSD interventions have been designed to address post-traumatic stress arising from single or non-interpersonal traumatic events. In recent decades, studies have increasingly reported differences in
manifestations of post-traumatic stress, such as emotional and interpersonal
difficulties, depending on exposure to interpersonal or non-interpersonal trauma, and
single or repeated traumatic events. This implies that traditional PTSD treatments
may not be sufficient in addressing these key difficulties (e.g., Briere et al., 2008;
Cloitre et al., 2013, 2005; Radford et al., 2013; Scott, 2007; van der Kolk et al., 2005).

2.8.2. Phase-based treatment

A three-stage model of trauma recovery has been proposed to address some of these
additional difficulties that occur after exposure to interpersonal trauma (Herman,
explained this model: The first treatment stage aims to equip trauma survivors with
emotion regulation and relationship skills, as well as self-care skills and adaptive
beliefs. They also receive psycho-education about trauma, the complexity of
symptoms and the recovery process. These aspects are aimed at stabilising the
patient and establishing a sense of safety through increased awareness and skills.
Thus, the risks of precipitating heightened anxiety, re-experiencing trauma events,
substance misuse, other comorbid symptoms and drop-out rates are reduced. This
stage prepares individuals for treatment stage two where trauma memories are
addressed with the aim of enabling them to mourn, reorganise and resolve trauma
events and to move on to live a more meaningful life. This second stage utilises the
benefits of conventional therapies that address trauma experiences directly early in
treatment. Stage three focuses outward on community involvement which may
include pursuing meaningful relationships, education, work, and leisure activities.
Again, this component is an addition to standard, mainstream treatment.

This phase-based treatment approach has been employed recently by clinicians. For
example, Cloitre and colleagues (2010, 2002) combined a Skills Training in Affect
and Interpersonal Regulation (STAIR) (stage one) with modified exposure (stage
two). These randomised controlled trials found that this type of skills training significantly improved affect regulation, reduced interpersonal difficulties and PTSD symptoms and had lower drop-out rates compared to STAIR or exposure treatment alone. A mixture of pilot studies and randomised control trials have reported that relationship-focused interventions without exposure were effective in that they moderated the symptom severity of PTSD and depression significantly as well as improving interpersonal functioning (Bleiberg & Markowitz, 2005 (pilot); Krupnick et al., 2008 (RCT); Markowitz et al., 2009 (RCT)). Some phase-based treatments have combined a manualised non-trauma-focused CBT approach for PTSD and for substance abuse and reported a significant decrease in the symptom severity of PTSD and in substance use in comparison with treatment-as-usual groups (Najavits, 2002, 2003). Some of these therapies are delivered as group treatment. For instance, Karatzias et al. (2016) found that group therapy based on the Trauma Recovery and Empowerment Model (TREM; by Fallot and Harris (2002)) reduced distress, anxiety, post-traumatic symptoms, and dissociation, and improved self-esteem in female adult survivors of interpersonal trauma. Though, it did not affect interpersonal, depressive and paranoid symptoms in this group.

These examples indicate that a phase-based intervention reduces trauma symptoms as well as emotional and interpersonal difficulties effectively. Perhaps this is due to the ‘whole-person philosophy’ that considers the person’s past, present and future, as well as emotional, social, cognitive, behavioural, and physical health (Courtois, 2004, 2014). However, overall little is known about the mechanisms and active ingredients of recovery from interpersonal trauma, not to mention specifically the mechanisms and key elements of emotion regulation and interpersonal skills improvement. Furthermore, Resick et al. (2012) cautioned about interpreting these results because most of the studies only compared treatment groups to participants on waiting lists or receiving usual treatment. In addition, they tended to include individuals with a history of childhood sexual abuse, but not with a history of neglect or emotional abuse or abuse in adulthood; and they included individuals
diagnosed with at least PTSD or Disorders of Extreme Stress Not Otherwise Specified (DESNOS) despite existing limitations of diagnosing and measuring interpersonal trauma experiences.

2.8.3. Other treatment approaches

Other treatment approaches target trauma effects within the body. For example, Sheynin and Liberzon (2017) discussed studies showing that sleep quality and behavioural exercise might affect hippocampo-prefrontal functions and, thus, cognitive processing. A review of qualitative studies on dance and movement therapy demonstrated that this form of treatment stimulated awareness through which meaning can be made, thus connecting the mind with the body (Levine & Land, 2016). However, the evidence for treating adult trauma survivors in these ways is not robust. Evidence regarding pharmacological treatment of PTSD is better established (e.g., Pradhan et al., 2016; Ragen, Seidel, Chollak, Pietrzak, & Neumeister, 2015; Sheynin & Liberzon, 2017). Administering oxytocin has been found to improve emotion regulation and trust (Charuvastra & Cloitre, 2008), although the effect appears to be less in individuals with a dysfunctional family background or higher attachment anxiety (review by Bakermans-Kranenburg & van Ijzendoorn, 2013). A review by Briere and Scott (2015) suggested that, while pharmacological treatment may target anxiety, depression, avoidance, re-experiencing and hyperarousal, there has been little evidence that drug treatment improves the personality or identity-related difficulties characteristic of complex trauma. In addition, research has indicated that psychotherapy was more effective than pharmacological treatment in reducing PTSD symptoms (e.g., Briere & Scott, 2015; Lee et al., 2016). Finally, with a few exceptions, the majority of these studies have not distinguished between interpersonal and non-interpersonal trauma so it has been difficult to compare the usefulness of body-focused PTSD interventions.
Most interventions for interpersonal trauma have addressed difficulties within the individual. While this is valuable, it has short-term effects, and very little is known about long-term interventions at the community, societal or cultural level (DeGue et al., 2012; Maercker & Hecker, 2016). Burton et al. (2015) suggested that the cultural background is an important consideration because it informs how we interpret traumatic events. Also, DeGue et al. (2012) argued that sexual violence prevention is difficult to implement in isolation. Thus, good individual treatment outcomes may be reversed where trauma survivors have returned to a victimising, unsupportive environment. Charuvastra and Cloitre (2008) cited research where trauma mobilised positive responses from others when distress was openly shared by many and collectively understood as heroic (e.g., victims of the recent fire at Grenfell Tower), and of trauma eliciting negative reactions when distress remained unseen and was collectively understood as shameful and ambiguous. The latter typically affects victims of sexual assault, intimate partner violence, and childhood maltreatment. Yet, few community interventions have addressed the influence of this collective understanding (DeGue et al., 2012; Mannell & Dadswell, 2017; van Dijken, Stams, & de Winter, 2015).

2.8.4. Beyond formal treatment – evidence from qualitative studies

There is evidence that about 42% of trauma survivors do not receive sufficient treatment (Hoge et al., 2014, as cited in Pradhan et al. (2016)), while 40% of trauma patients do not benefit from individual PTSD treatments (Bradley et al., 2014, cited in Maercker & Hecker, 2016). This may be partly due to misdiagnosis, long waiting lists or treatment being unavailable locally. Yet, these figures might also suggest that formal treatment or the way it is evaluated might be overlooking other important factors.
Some qualitative studies have reported key elements and processes involved in recovery overall. For example, they included remembering the past to prevent relapse, sharing one’s story, spirituality (Banyard & Williams, 2007), and regaining control, responsibility and a sense of self, and accepting the past (Roberts & Wolfson, 2004). Various factors hinder, enhance and challenge recovery (Chouliara et al., 2014), and four recovery stages involving grappling with the meaning of abuse, figuring out the meaning of abuse, tackling the effects, and laying claim to one’s life have been explored (Draucker et al., 2011). Oaksford and Frude’s (2003) study interviewed 11 female survivors of childhood sexual abuse, using grounded theory, to investigate changes in short-term and long-term coping strategies over time. They found that some strategies, such as escape, may be typical for immediate coping, while others were adopted solely in the long-term, such as reappraisal and positive reframing. Understanding this shift in coping strategies is useful. Yet, it appears as if adult survivors produced this shift from within themselves so the study placed the individual survivor at the centre of an understanding of coping strategies, while disregarding external factors. Stige, Træen and Rosenvinge (2013) conducted a hermeneutical-phenomenological study with 13 female participants exposed to human-inflicted trauma. They identified an evolving process leading to help-seeking from (1) initially managing on one’s own, then (2) facing situational challenges that exceeded one’s available resources, (3) a sense of losing control, (4) ‘being at the end of the rope’, (5) seeking help, often after years and decades, and finally to (6) developing a perceived need for help. This study contributed important knowledge to our understanding of the long-term processes involved in disclosure, but it did not reveal how this process continued post disclosure, and how disclosure unfolded in more diverse samples not in a therapy programme.

Two systematic reviews of qualitative studies have been published. One has investigated how adult survivors of childhood sexual abuse benefit from talking therapies (Parry & Simpson, 2016). Survivors reported benefit from the connection they formed in a therapeutic relationship, from developing a sense of self, from
gaining insights about shedding light on traumatic experience, relationships and oneself, and from connecting with others and experiencing a sense of togetherness. The second review evaluated how adults heal from sexual violence experienced in childhood or adulthood (Draucker et al., 2009). Survivors reported conflicting experiences between (1) escaping traumatic memories versus being drawn to them, (2) keeping others out versus seeking them out, (3) seeking safety versus reforming the lifeworld, and (4) repairing damaged aspects of the self versus protecting one’s identity.

Most qualitative studies in this area have focused on childhood sexual abuse and only a few exist on child maltreatment more generally and on intimate partner violence (e.g., Lim, Valdez, & Lilly, 2015). Similar to the phase-based approach, these alternative ideas have also considered the person as a whole. In addition, they investigated what makes recovery personally meaningful (Chouliara et al., 2014). However, they only focused on trauma recovery more generally, while not explaining the processes and key elements involved in improving core issues, namely emotion regulation and interpersonal difficulties. Yet, these qualitative studies do suggest a useful approach to investigating these core issues.

2.9. Gaps in knowledge

Several recurrent gaps have been identified throughout existing research on interpersonal trauma. Firstly, the most striking shortcoming about this research is that it has placed trauma survivors predominantly at the centre of understanding their deficits and has thus regarded interpersonal trauma as a problem primarily within the individual that needs repairing. While it is valuable to understand individual difficulties, emphasising these too much might risk stigmatising the individual survivor and overlooking contextual factors. Bryant (2016, p. 5) gave a timely reminder that researchers agree that “trauma does not occur in a social
vacuum and we need to appreciate the role of interpersonal and societal factors”, however, concepts related to trauma have not adequately addressed environmental aspects. In particular, the dominant focus on cognitive aspects of post-traumatic stress, of attachment, of resilience, and of emotion regulation has shifted attention to internal mechanisms, thus contributing to an overly narrow understanding in this field. For instance, post-traumatic stress appears to be characterised by the individual’s inability to mentally control their impulses and overwhelming feelings such that there is an emphasis on treating this lack of internal control with cognitive-based interventions, such as trauma-focused CBT or psycho-educational skills training. Attachment theory highlights the development of unfavourable mental representations of the world after exposure to trauma. Equally, cognitive processing and reappraisal after trauma has been shown to weave throughout and shape other concepts (e.g., resilience, post-traumatic growth, and emotion regulation). The emphasis of these constructs on the internal mental world of the individual survivor attributes trauma-related difficulties predominantly to that individual. Consequently, proposed solutions for trauma are largely believed to be found or developed within the individual survivor. But does this understanding and approach truly reflect trauma and recovery? Considering that it was environmental factors (i.e., exposure to abuse or neglect from another person) that contributed to developing trauma-related difficulties, it is surprising that solutions are not also sought predominantly in the social environmental sphere. Therefore, this deficit needs addressed by seeking to explain the dynamic interaction between an individual survivor and environmental circumstances and between an individual survivor and other people.

Secondly, there has been a bi-directional understanding of what factors put trauma survivors at risk and what factors contribute to their recovery. Certain forms of thinking, feeling, behaving and interacting have tended to be seen as maladaptive while certain other forms are generally viewed as adaptive. For example, avoidant coping has been understood as problematic while active coping has been
understood as beneficial. However, it may not be that black and white. Thus, research risks underestimating the complexity of human life and, disregarding the wider social context. In other words, a certain coping strategy might be useful in one situation and problematic in another. For instance, Foster et al. (2015) found in their qualitative study that avoidant coping may prevent the escalation of intimate partner violence, and Joseph et al. (2012) indicated that rumination may be a way to work something out, and perhaps an attempt at cognitive (re)appraisal. It is important for research to now address how context influences the use of different coping strategies and the usefulness of various strategies.

Thirdly, the processes and factors by which individuals improve with regard to emotion regulation and interpersonal difficulties in trauma recovery remain relatively unknown. It is true that there is considerable understanding of what specific emotion dysregulation and relational difficulties are experienced by trauma survivors. There is also wide acceptance that effective treatment (or recovery) outcomes include improvement in regulating emotions and in relating to others. Yet, there is little understanding of how treatment techniques and recovery tools facilitate a shift within a person from emotional and interpersonal difficulties towards recovery. Although research has identified effective treatments that address the emotional and relational impairments resulting from interpersonal trauma and the processes and factors involved in overall trauma recovery, studies have failed to explain sufficiently how survivors of interpersonal trauma learn to regulate emotions and gain interpersonal competence.

Fourthly, previous studies have failed to differentiate PTSD by trauma types, or they vary greatly in terms of their inclusion criteria regarding interpersonal trauma. Many studies have assessed general PTSD without considering that different traumatic life experiences may impact differently on other aspects under scrutiny, such as emotion regulation. Also, some studies have investigated only experiences of physical and sexual abuse. Other studies added neglect and emotional abuse to
their investigations. A few studies included experiences of combat and witnessing violence. This ambiguity is problematic because it has resulted in different measurements being used to assess trauma exposure, and in divergent research results regarding symptoms and treatment. For example, many different questionnaires have been developed for use in this field, such as the Childhood Trauma Questionnaire, Life Events Checklist, Stressful Life Events Screening Questionnaire, and Traumatic Life Events Questionnaire (e.g., Cloitre et al., 2013; Kim et al., 2009; Krupnick et al., 2008; Lim et al., 2012; McDermott, Tull, Gratz, Daughters, & Lejuez, 2009; Sandberg et al., 2010). Consequently, these diverse inclusion criteria and definitions have made it difficult to compare results across studies and might have compromised the validity of some study outcomes.

Next, most studies on interpersonal trauma are limited to PTSD or DESNOS diagnoses. However, interpersonal trauma is characterised by a complexity of comorbid symptoms, such as depression, schizophrenia, anxiety, dissociative disorder, substance use disorder, eating disorder, somatic symptom disorder or personality disorder (e.g., Grubaugh, Zinzow, Paul, Egede, & Frueh, 2011; Read et al., 2004). Due to this complexity, there is disagreement in diagnostic criteria for interpersonal trauma either with PTSD and other disorders, with DESNOS or with Complex PTSD. Several studies have defined interpersonal trauma based on a PTSD diagnosis (e.g., Iverson et al., 2011; Taft et al., 2009; Ullman et al., 2013). However, according to Cloitre et al. (2009), Courtois and Ford (2009), Herman (1992), and van der Kolk et al. (2005), PTSD describes responses to single non-interpersonal traumatic events better, whereas DESNOS and complex PTSD capture complex, particularly self-regulatory, responses associated with repeated, interpersonal and early-onset trauma. Overall, this lack of consistency across studies is problematic. If studies of interpersonal trauma only included cases where trauma survivors have been diagnosed with PTSD or DESNOS then study outcomes do not adequately reflect the complexity of interpersonal trauma (van Ee et al., 2016).
Furthermore, many studies of interpersonal trauma have been limited in that they excluded trauma survivors whose history of abuse was unknown. According to Courtois (2004) and Pereda et al. (2009a), some individuals may be reluctant to disclose traumatic experiences to the clinician. Others may be unable to recognise traumatic experiences as abuse or may have forgotten incidents (Finkelhor et al., 2014; Grubaugh et al., 2011; Pereda et al., 2009a). Similarly, health professionals may fail to ask for or to follow up an underlying trauma history (O’Doherty et al., 2014; Tierney, 2014). As a result, these individuals may not be diagnosed with PTSD or DESNOS and research risks excluding these people from studies. This has implications for the interpretation of findings.

Another limitation of previous research is the use of methods to assess trauma symptoms, attachment, resilience, cognitive appraisal, emotion dysregulation and interpersonal difficulties. Most studies have used retrospective self-reports and cross-sectional designs only. A few objective measures have been employed (e.g., Basu, Levendosky, & Lonstein, 2013; Bruce et al., 2013; Heath et al., 2013). However, most studies are limited to narrow subjective accounts of participants’ experiences. This introduces bias, compromises validity and provides little room for people to recount a personal narrative of their experiences. The lack of prospective, experimental and longitudinal studies also limits our understanding of causality and development over time.

Finally, the majority of research in this area comprises quantitative studies. These studies have contributed to considerable progress and a better understanding of interpersonal trauma. However, they cannot capture the depth and wealth of participants’ views and, thus, fail to give trauma survivors an authentic voice. A few qualitative studies have begun to investigate the totality of individuals’ trauma experience but more is needed (Joseph et al., 2012).
2.10. Aims and objectives

On the basis of this literature review, my research project aims to explore the processes and factors involved in recovering from experiences of interpersonal violence and subsequent trauma. In particular, the literature has shown that adults with a history of interpersonal trauma have difficulties in managing emotions and relating to others. This study will investigate what factors and processes assist them in managing these better and, subsequently, facilitate a shift towards improved emotion regulation and interpersonal competence. The present study will use an inclusive definition of interpersonal trauma, a female UK population and a qualitative approach. This research will generate novel theoretical understanding regarding two core issues of interpersonal trauma recovery, namely emotion regulation and interpersonal functioning. This research will have clinical and societal implications. Study outcomes will not only inform services to facilitate survivor-centred recovery but could also be used to improve training of professionals and treatments for trauma survivors (Chouliara et al., 2014) and strengthen communities.
Chapter 3: Methodology and study protocol

3.1. Introduction

The following chapter will outline the research paradigm and methodological choices made for the current study. It will begin with a discussion on the assumptions made about what can be known (ontology) and how this knowledge can be obtained (epistemology). This will then inform the methodological approach for this study – here a qualitative approach. There are several qualitative methods for collecting and analysing data. Some of these will be examined and an argument presented for why grounded theory is a suitable choice for this particular research. Building on this, the specific techniques for gathering information, such as sample, research sites, study material, ethical considerations, data management, recruitment, and interviewing, will be described. For any study results to be believable, it is important to ensure the quality of the research. Therefore, it will be examined how credibility, transferability, reliability, and researcher expertise were achieved. A major component in this piece of research alongside data collection and analysis was the use of a research diary. This tool will be discussed together with the need for reflexivity. The chapter will conclude with data analysis procedures.

3.2. Ontological perspective

When undertaking research, philosophical perspectives have to be considered that inform subsequent methodological choices. That is, the researcher is required to think about the view he or she takes regarding what he or she believes can be known
(ontology) and how he or she can know this (epistemology). Ontology and epistemology are concerned with these aspects. They provide a set of principles which shape researchers’ questions and the research techniques to answer these (Grix, 2002; Guba & Lincoln, 1994). Ontology is concerned with what can be known about the real world, what kind of world we live in, and what can be true about it (Bryman, 2012; Denzin & Lincoln, 2008, 2011; Goertz & Mahoney, 2012; Grix, 2002; Guba & Lincoln, 1994). Ontological positions come with assumptions about the world or about specific phenomena within it. While there seems to be disagreement over what terms to use on the ontological level and for different ontological positions, there tend to be two distinct perspectives. Here, these will be referred to as realism and relativism (Guba & Lincoln, 1994; Wetherell & Still, 1998).

Realist assumptions assert that there is “an unquestionable faith in the reality of what we perceive” and the researcher explores what of these perceptions is real and truly exists, what is illusion, bias and misconception and what exists externally of what is currently known and is waiting to be discovered (Bryman, 2012; Wetherell & Still, 1998, p. 99). It also asserts that reality is not influenced by ‘social actors’ (Grix, 2002). By contrast, relativist assumptions assert that there are multiple knowledges and realities of what can be known about the world and specific aspects within it (Bryman, 2012; Grix, 2002; Wetherell & Still, 1998). The reality of things is dependent on the perspective of the different actors or group of actors in the world and is subject to change over time and place (Gergen, 1985; Grix, 2002; Wetherell & Potter, 2015; Wetherell & Still, 1998). Researchers have begun to question this dualistic view of realism vs. relativism and, instead, view ontological assumptions on a continuum whereby the world may be understood at different degrees of

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1 For example, Grix (2002) and Denzin and Lincoln (2008) use objectivism vs. constructivism on the ontological level; Wetherell and Still (1998) and Guba and Lincoln (2005) use realism vs. relativism on the ontological level, Charmaz (2014) uses positivism vs. interpretivism on the ontological level. However, Fletcher (1996) uses realism vs. relativism on the epistemological level, and Wetherell and Still (1998), Gergen (1985) and Bryman (2012) use constructionism on the epistemological level.
realism and relativism (e.g., Fletcher, 1996; Guba & Lincoln, 2005; Westerman, 2014; Wetherell & Still, 1998; Willig, 2013).

For this study, a relativist position was taken with the assumption that concepts around trauma and recovery may be understood differently among those who have been abused, as well as health care professionals, researchers and the present investigator. This difference is dependent not only on the unique perspective of each group as a whole – for example, the abused person who lives with the experience, the professional who attempts to treat day-to-day difficulties, and the researcher who attempts to provide evidence of trauma and interventions – but also on the unique perspective of each individual within these groups. For example, one person might have experienced long-term childhood physical abuse with simultaneous access to nurturing social support outside that abusive environment and grows into adulthood with only few day-to-day difficulties. Whereas another person might have experienced domestic abuse as adult only, with very limited social support and becomes unable to manage daily life as a result.

Similarly, the literature review demonstrated that multiple knowledges emerged with regards to what constitutes interpersonal trauma (in the historical context as well as in the present), who counts as abused, neglected, or traumatised, and how difficulties of managing feelings and interactions are conceptualised. For example, with regards to interpersonal trauma, a common realist position asserts that a person is understood as trauma survivor if (1) he or she has had an experience of adversity that threatened their life and their integrity whereby the threat was initiated by another person, and (2) displays a set of long-term difficulties, and usually a diagnosis of PTSD. However, this can be problematic because what one person might regard as threatening may not be recognised as a threat to someone else. This could be seen in the literature on interpersonal violence where only physical and sexual childhood abuse was regarded harmful while emotional abuse and neglect has only been considered recently. Similarly, some people exposed to
violence, yet affected by it long-term, may not perceive their experience as constituting abuse and, therefore, might not disclose it nor receive the common diagnosis of PTSD that would give access to treatment (van Ee et al., 2016). Alternatively, some individuals exposed to interpersonal violence and affected by it might disclose their experience of abuse to health care professionals but the latter might not recognise it as abuse or trauma. With reference to the current study, the researcher attempted to maintain an open mind to participants’ experiences and their conceptualisation (if any) of scholarly concepts, such as ‘interpersonal trauma’, ‘emotion regulation’, ‘relatedness’, ‘recovery’, and being a so-called ‘trauma survivor’. This also considers that participants may define these terms not only differently to the literature and among themselves, but may also define them in an entirely new light.

3.3. **Epistemological perspective**

Once the researcher determines what can be known about certain concepts, he or she can concern themselves with the epistemological level of how we come to know this reality of the world. That is, the researcher asks questions of how this knowledge can be gained and validated, and how it can develop, refine and challenge models or theories (Denzin & Lincoln, 2008, 2011; Grix, 2002). Again, there are two distinct positions on this level. As with ontological perspectives, different terms are being used for these epistemological perspectives. Here, they will be referred to as positivism and constructivism (Denzin & Lincoln, 2008, 2011). The former tends to follow a realist philosophy while the latter follows a relativist philosophy.

Positivism asserts that we can only know the real world through observations and experimentation (Denzin & Lincoln, 2008, 2011). It tends to investigate the natural, physical world in a controlled environment and attempts to measure and predict (Bryman, 2012; Grenon & Smith, 2011; Grix, 2002; Guba & Lincoln, 2005). The
researcher takes a detached position of the external, independent and unbiased observer while the participant is the object to be investigated and tested. By contrast, constructivism asserts that the world can be known through social interactions and by interpreting or meaning-making of those interactions (Berger & Luckmann, 1966; Bryman, 2012; Charmaz, 2014; Gergen, 1985; Goertz & Mahoney, 2012; Grix, 2002). The researcher is part of this meaning-making process. That is, he or she is involved, has an influence on the knowledge that is being created as much as the participant, and his or her pre-existing experience has an influence on the participant and the outcome. Some authors consider realists/positivists as less reflective of their own influence on their experiments and the interpretation of results, although they equally take an active role in creating and interpreting results that could lead to bias/construction (e.g., Bryman, 2012).

For this study, a constructivist position was taken with the assumption that knowledge can be gained by interacting with participants. Both, the participants and the researcher interpret each their own world that they bring to the interaction (e.g., the participant expresses their interpretation of their own day-to-day difficulties and recovery experience in an interview) but they also interpret the interaction that they have together. They co-create meaning. This contrasts with most previous research in the field of interpersonal trauma which is largely positivist. Such research measured physiological or neurological aspects to determine threat or stress responses of individuals exposed to abuse, or used standardised questionnaires with a set of defined items to determine a PTSD diagnosis. Although these studies appear to give certainty over whether someone suffers trauma or not, previous research and the history of trauma shows that this is not straightforward. For example, measurements testing for trauma, when conceptualised as PTSD only, have been less likely to detect trauma in individuals exposed to interpersonal traumatic incidents despite them suffering from various day-to-day difficulties (later conceptualised as DESNOS). Similarly, where knowledge about trauma is assumed to be gained only by testing a group of
veterans, trauma in women exposed to childhood sexual abuse or adult sexual assault would remain undetected, or – where it is generalised to other groups – different internal experiences of trauma would be ignored.

The current study aims to make space for diverse recovery experiences of adults who have been exposed to interpersonal violence. It does not seek to measure or generalise. Instead, it seeks to understand – in interaction with the researcher – how these adults construct their own experience of trauma, recovery, managing emotions and handling relationships (whatever these terms mean to them). This also implies that what will be known at the end of this study will only be one part of a wider body of knowledge containing multiple understandings of trauma, recovery, and emotion regulation and interpersonal difficulties. Additionally, findings will be constructed around a certain population and in a defined culture, time and location.

3.4. The researchers professional and personal assumptions

While it is common to disregard personal assumptions with a realist/positivist position (Guba & Lincoln, 2005), the choice of a relativist/constructivist position for this study requires taking the researcher’s assumptions into account. Five assumptions have been identified. These refer to prior research experience, prior work experience in the field of mental health and trauma, personal experience and view of interpersonal trauma, a feminist standpoint, and British culture with Western ideology.

Firstly, the researcher’s prior research training and experience originates mostly from a realist/positivist background. The attended undergraduate and postgraduate taught degrees in psychology focused, particularly, on quantitative research methods, whereas relativist/constructivist perspectives and qualitative research
methods were marginal components. This background may have an influence in the following study where the researcher might revert back to positivist deductive methods without noticing. As a result, the quality of this study may be affected. To minimise this, the researcher consulted with supervisors, and documented and reflected on her approach in a research diary.

Secondly, the researcher has prior experience of working with adults with mental health difficulties and, in particular, with adult survivors of interpersonal trauma. This experience might be both an advantage and disadvantage. While prior work experiences with this population may have heightened the awareness of and challenged the researcher’s previous assumptions (thereby minimising possible distortions in this study), it may equally have formed new assumptions that could influence data collection and analysis of the present study. Additionally, the researcher worked at the community research site prior to data collection. This exposure influenced the current study in that the researcher had built rapport with some community members who, later, became participants of this study; and because of this rapport, participants may have felt more comfortable to disclose information during research interviews. However, it also might have made the researcher blind to unique characteristics of the service and its users. In this respect, including a second, and considerably different, research site into the study, assisted in re-emphasising characteristics that were also unique to the community site. A conflict of interest was reflected upon, but excluded for three reasons: The present study was not conducted under paid conditions with this community site; it was not conducted for establishing service outcomes; and it was limited to minimal and practical input from community staff with regards to decisions of data collection and analysis.

Thirdly, the researcher’s personal experience and view of interpersonal trauma may influence the outcome of the current project. Considering that approximately one in three women experience abuse, it is not surprising that the researcher witnessed domestic violence, and was exposed to – what may be regarded as – emotional abuse.
in the past. Disclosing this experience to participants might have meant that rapport could have been built quickly, but also that both parties would assume to share a common understanding. This was regarded as counterproductive. Therefore, the researcher indicated ignorance about interpersonal violence, trauma, and recovery to elicit more descriptive and explanatory information from participants. In another way, the researcher’s own experience with abuse and recovery proved an advantage. While the analysis compared and contrasted between research participants’ experience, the researcher also gained analytic insight when similarities and difference between participants’ and her own experience surfaced. These surprises were recorded and reflected on in the research diary.

Fourthly, the researcher took a feminist approach which advocates for participants’ interests (Hall, 2011) and minimises the hierarchy between participant and researcher (Campbell, Adams, Wasco, Ahrens, & Seifl, 2010). To achieve this, the researcher presented herself to participants as the curious and empathic friend. She also involved them in feedback on study material, tuned in and responded to participants’ emotions, and emphasised the level of control participants had during the research. Smith (2014, p. 113) suggests that “[f]eminism reframes symptoms as normal and understandable responses to traumatic or destructive experiences”. Feminism also considers the individual female’s experience of violence, trauma and recovery as well as the social influences that may produce violence against women or may impede their recovery. In this sense, it investigates underlying power dynamics of phenomena, such as trauma recovery, and attempts to challenge these. Thus, it was assumed that the research results may reveal such power dynamics.

Finally, British culture and a Western ideology may have shaped this research. These systems assume that the cause for illness and the responsibility for well-being lie predominantly with the individual. However, as Charmaz (2014) highlighted, this dismisses influences of social causes and social solutions. In the present study,
the researcher did not wish to favour one over the other but, instead, aimed to consider both possibilities.

3.5. Methodological considerations

What follows from these philosophical decisions are methodological choices that must be made. Methodology is concerned with the best way to acquire the kind of knowledge the researcher seeks. It requires assessing possible approaches for their strengths and weaknesses, and their suitability for the study at hand to come to a logical conclusion why one approach is chosen over another (Grix, 2002). For the current study, a qualitative approach was chosen over a quantitative approach. According to Denzin and Lincoln (2011), qualitative research encompasses a wide range of philosophical positions, practices, contexts, and materials and, therefore, it is difficult to define. In brief, qualitative research uses ‘interpretative naturalistic approaches’ to understand the world. It uses materials, such as “field notes, interviews, conversations, photographs, recordings, and memos to the self”, which represent this world of which meaning is made in this interpretative process (Denzin & Lincoln, 2011, p. 3).

Qualitative research tends to interpret non-numerical information, such as texts and images, for its complexity and varying attributes in context (Creswell, 2013; Denzin & Lincoln, 2011; Goertz & Mahoney, 2012). Its flexibility helps generate data that are rich, detailed, diverse and subjective (Abusabha & Woelfel, 2003). This is useful for the present study because it seeks to understand the subjective, rich and unique experiences of participants’ trauma recovery, and their emotional and interpersonal functioning. A qualitative approach also provides the range and depth of emotional and social experiences that are meaningful to traumatised individuals on their recovery journey – and it is this complexity that the present study seeks. According to Creswell (2013), speaking directly to people will not only gain detailed insight
into a subject area, but will also give participants a voice where their experience normally remains hidden and unexpressed. This is particularly the case with experiences of interpersonal violence and how individuals live through subsequent difficulties. A qualitative approach can facilitate this voice-giving because it allows participants to engage, and be the main contributor of information in a conversation with the researcher. Creswell (2013) also suggests that qualitative methods are useful when exploring questions that have not been asked in this way before. This is the case with the present study and, therefore, an exploratory approach and open mind through qualitative methods will provide an advantage. It may also allow questioning the concepts of recovery, trauma, emotion dysregulation, and interpersonal difficulties themselves, where most quantitative research may have imposed meaning. Furthermore, qualitative methods match well with the chosen relativist position where phenomena are considered as socially constructed (Denzin & Lincoln, 2011; Gergen, 1985; Wetherell & Still, 1998; Willig, 2013).

Nonetheless, this choice comes with several restraints that require consideration. Firstly, while findings of the present study will identify and define some patterns and key components, findings will not identify, measure and define these as distinctly or in the same way as quantitative research does. However, this is acceptable considering the purpose of this study. Existing literature has indicated that the measuring and defining of concepts, such as emotion regulation, trauma, and trauma interventions, might narrow down the information received and, thus, may miss the complexity of trauma recovery and its emotional and interpersonal components. By contrast, the present study will seek this complexity and, thus, may be restricted to broader patterns and overarching components. Secondly, this study will also not determine correlations or cause and effect to test and develop coherent theories as is common in quantitative research (Kuhn, 1970; McGhee, 2001; Wetherell & Still, 1998); though the qualitative results may suggest possible relationships and processes among emerging concepts which will contribute to developing new theory. Thirdly, questions have been raised about bias and a lack of reliability,
validity, generalisability and objectivity in qualitative research and, therefore, their usefulness has been questioned before (Abusabha & Woelfel, 2003; McGhee, 2001; Rapley, 2003; Richards, 2002). By contrast, researchers argued that these concern may be less applicable to qualitative research (e.g., Rolfe, 2006; Trochim, 2006). Achieving quality in the current study will be discussed in sections 3.13 and 3.14.

Several qualitative methods have developed over the years from which researchers can choose. To name but a few, these include thematic analysis, interpretative phenomenological analysis (IPA), narrative analysis, grounded theory, discourse analysis, or conversation analysis. When comparing these methods, they share the following features (Willig, 2013): Most of these have in common that they question not only what a piece of text or a person says, but also how it is said, and what it means. In particular, the latter (i.e., meaning-making) implies a degree of interpretation and construction. Therefore, these methods consider findings a result of a co-production between the writer/interviewee and the researcher, and of the researcher’s interpretation of the data. Each actor in this process makes decisions about what to write, tell, ask and make sense of. Therefore, the experiences the researcher collects on a specific topic are expected to be different from one source of information to another. To gain awareness of and document the level of co-production and interpretation, most of these qualitative methods advocate reflexivity to various degrees. Furthermore, these types of qualitative analyses aim to identify descriptive and analytic themes, and develop connections between these. However, their procedures differ. Finally, they aim to provoke individual or social change.

These common features alone will not help determine the most appropriate method for the current study. Instead, one needs to understand their differences and the advantages or disadvantages resulting from variations. In this regard, for example, IPA investigates how a person perceives the world around them in a given time, place or situation. This might be useful for this study because it explores what it is like to cope after exposure to interpersonal violence and with subsequent trauma. IPA,
however, emphasises perception to such an extent that it does not account for the way people talk about a given experience and that this *talking about* also shapes the information that is being analysed (Willig, 2013). This would be problematic if, for example, a participant has difficulties expressing their innermost thoughts, feelings and opinions in language. A study using IPA would only capture what participants are able (and prepared) to express but would present it as if this were the actual experience. Other methods, such as narrative analysis and constructivist grounded theory, face the same challenge. However, these methods build the construction of information into their analysis and emphasise reflexivity. Narrative analysis, for instance, considers how the narrator of a piece of text constructs the life story they tell another, how he or she organises the beginning, middle and end of their story, and how he or she presents the setting, other characters, events, attempts, outcomes and reactions (Willig, 2013). The focus is less on the event and, instead, on how the story is told from the narrator’s point of view. For the current study, this method might be suitable because it can uncover how trauma survivors construct their life story around their recovery from abuse. Hall (2011) provides a working example in her study of women survivors of childhood maltreatment. Also, narrative analysis could answer the research question of key ingredients as well as key processes, because it focuses on action, events, and actors. However, it cannot develop a theory of emotional and interpersonal trauma recovery, and appears to employ a less systematic protocol for data collection and analysis. By contrast, a grounded theory method could produce a model of recovery while ensuring quality with a set of analytic procedures of coding, categorising, theoretical sampling, memo writing, and theory-building. Both, grounded theory and narrative analysis, can embed individual stories in a larger social, historical and cultural context in which events occurred and in which narrators tell about these events (Charmaz, 2014; Chase, 2005; Willig, 2013). By contrast, IPA disregards “past events, histories or the social and material structures within which we live our lives”, and only describes, but does not explain, lived experiences and underlying conditions (Willig, 2013, p. 95). However, the present study aims to capture past events and social conditions that may have
influenced how people cope after interpersonal traumatic events. It assumes that these experiences involve a long-term journey based on evidence that disclosure and help-seeking can take years (Allnock & Miller, 2013; Kogan, 2004; Smith et al., 2000), and begins with the traumatic event. It also assumes that recovery aspects might not only originate from the individual’s own action and beliefs, but also from external factors and social structures. IPA may be less equipped to capture this larger picture.

3.6. **Grounded theory**

3.6.1. **Defining grounded theory**

This study adopted a grounded theory approach. Grounded theory is both, a systematic method to collect and interrogate data, and the end-product – an inductive theory – of this analytic and interpretative process (Charmaz, 2014; Glaser, 1992; Willig, 2013). Grounded theory implies that the developed theory is ‘grounded’ in the data from which it has emerged (Glaser’s (1978, 1992) and Strauss and Corbin’s (1990, 1998) version) or from which it has been constructed (Charmaz’s (2014) version). In other words, the researcher avoids using a deductive approach whereby data are forced into pre-existing categories, ideas or hypotheses and, instead, he or she uses an inductive approach whereby categories, themes and theory are developed fresh from the data, staying as close to these data as possible (Charmaz, 2014; Sbaraini, Carter, Evans, & Blinkhorn, 2011; Willig, 2013). Thus, grounded theory is considered an open and flexible approach that does not lend itself to a rigidly prescribed analytic process.

3.6.2. **Suitability of grounded theory for this study**

This method was suitable for the current study because, firstly, it allowed the researcher to answer *how* participants cope with and recover from interpersonal
Making the invisible visible: A grounded theory study...

trauma. Grounded theory tends to study such processes and actions, and focuses on the how of social phenomena rather than the meaning of people’s experiences (as would, for example, a phenomenological approach) (Charmaz & Henwood, 2008; Holstein & Gubrium, 2003b; Willig, 2013). Because grounded theory has its origins in sociology and social psychology, here it can capture not only actions that are characteristic of the individual but also their interaction with the environment that might contribute to trauma recovery. Secondly, the present study sought to contribute to a model of trauma recovery that includes emotional and interpersonal components. Compared with other qualitative traditions, grounded theory was best suited here because it concentrated on theory-building, while being grounded in the generated data; and it followed a set of systematic procedures to ensure quality (Charmaz, 2014; Charmaz & Henwood, 2008). Yet, this method also allowed the researcher to stay open and flexible to the insights that unfolded during analysis (Charmaz, 2006, 2014).

3.6.3. A constructivist grounded theory study

Grounded theory has developed over recent decades, and from this development three distinct methods have emerged: Glaser’s (1978, 1992) classical grounded theory, Strauss and Corbin’s (1998) Straussian grounded theory, and Charmaz’s (2014) constructivist grounded theory. There are general strategies that grounded theory – regardless of being classic, Straussian or constructivist – employs. These have been relevant for the current study. According to Charmaz (2014), Charmaz and Henwood (2008), Flick (2009), Glaser (1992), Holstein and Gubrium (2003b), Sbaraini et al. (2011), Strauss and Corbin (1998) and Willig (2013), these strategies involve:

- A simultaneous and cyclical process of both data collection and analysis. This implies that data are not analysed after data collection finishes, but rather immediately and alongside collecting further data.
Inductive analysis where general processes emerge, or are constructed, from the collected data

- An openness and flexibility to what can be found
- Coding extracts of relevant data, and categorising data to reassemble and shed new light on it
- Constant comparison of data, codes, categories, concepts to identify similarities, differences, negative cases, relevance and fit
- Memo-writing to capture – through writing – the analytic process and any insights and questions regarding similarities, differences, connections, assumptions, relevance and fit
- Theoretical sampling which involves collecting additional data to refine the properties of categories and the theory, and leads to theoretical saturation – a point at which no further insight is revealed
- Theory-building to discover or construct basic processes
- Using literature as additional data to situate the emerging/constructed theory

For the current study, constructivist grounded theory was chosen because it corresponds with the adopted relativist ontological and constructivist epistemological perspective (Charmaz, 2014; Evans, 2013). Thus, this study assumed that the researcher brings with her some pre-existing knowledge of trauma recovery, emotion regulation and interpersonal aspect, as well as her life experience and her own position in the social world. Her assumptions as well as her interaction with participants and the data have actively constructed, rather than discovered, the findings and the subsequent theory. It was also assumed that the data only reflect the perspectives of the selected trauma survivors (and not, for example, of non-help-seeking adults with experience of abuse or trauma, or professional trauma specialists). Thus, findings may only reveal part of the complete picture of trauma recovery, and the developed theory allows modification through reinterpretation and new data (Breckenridge, Jones, Elliott, & Nicol, 2012). Additionally, constructivist grounded theory was appropriate for this study because it does not
seek to present the researcher’s interpretation as an authoritative view of what trauma recovery entails, as may have been the case with an objectivist approach. This is suitable when working with trauma survivors because constructivist grounded theory may be less likely to impose the researcher’s view on participants and, thus, be less likely to silence those who have been silenced before.

Evans (2013) have criticised the arbitrary switching between different grounded theory methods which can introduce serious methodological flaws. Therefore, highlighting the unique tools and procedures for doing constructivist grounded theory at this point aims to ensure rigour.

A review was undertaken by Evans (2013) which compared classic, Straussian, and constructivist grounded theory. While both classic and constructivist grounded theory begin by choosing a particular area for their inquiry, the constructivist version has a specific research question in mind. In the present study, the research question is how adults suffering from trauma recover after exposure to interpersonal violence and how they gain emotional and interpersonal skills. Secondly, constructivist grounded theory allowed a literature review prior to the study in order to identify previous research on the chosen topic. By contrast, in classic grounded theory, literature can be integrated as additional data, but only after a theory has been sufficiently developed. Thirdly, Charmaz uses three coding stages: open or initial coding, focused coding and theoretical coding, whereas Glaser only uses open and selective coding, and Strauss and Corbin use open, axial and selective coding. Consequently, there are different meanings to coding: Charmaz regards theoretical coding as the process that allocates focused codes into further, and more abstract, groups. For Charmaz, this process takes place throughout the analysis. Glaser views theoretical coding as part of the selective coding only. Inherent in Strauss and Corbin’s coding method is that they seek to identify properties and dimensions of abstract analytic codes. This is not the case in Glaser’s and Charmaz’s version where the refinement of properties of abstract concepts is
more flexible and less-defined. Fourthly, language plays a greater part in constructivist grounded theory where it aids in the interpretation, and therefore construction, of the data. Fifthly, classic grounded theory is less compatible with data analysis software than the constructivist version. Finally, Evans (2013) suggests that using a constructivist method might result in descriptive rather than explanatory theories.

At this point an overview has been given of different ontological, epistemological and methodological perspectives requiring consideration, and these have been evaluated with respect to their suitability for the current study. A relativist and constructivist position with a qualitative methodology and, particularly, a constructivist grounded theory method have been justified as appropriate. Now, the applied study protocol will be considered.

### 3.7. Participants and inclusion criteria

The present study was conducted in Scotland, and recruited adult trauma survivors from a statutory trauma specialist service and from a local community development project. The following inclusion criteria were used: Firstly, adults were over 18 years old. Secondly, people who had experienced any number of traumatic events of interpersonal nature (e.g., exposure to physical, sexual and/or emotional abuse at any stage in their life, and/or emotional or physical neglect in childhood, or the witnessing of such events). To keep with the exploratory approach, this study allowed the participants to identify what has been abusive or neglectful in an interpersonal context to them. An assumption was that professional gatekeepers from the selected trauma-informed research sites understand what comprises physical, sexual and emotional abuse, and childhood neglect. Thirdly, these adults needed to have previously disclosed exposure to such interpersonal traumatic events in order to increase participants’ and the researcher’s safety and to minimise
disruption during the interview. Safety and continuation of the interview may be at risk from overwhelming distress of first-time disclosure.

Fourthly, adult trauma survivors should be in contact with support services and engage in recovery processes (such as talking to friends or professionals, reading self-help books, exercising, doing arts and crafts, participating in online forums or face-to-face support groups, or taking part in individual or group therapy with health care providers). The definition of ‘engagement in recovery’ was kept open intentionally as it fitted well with the exploratory aspect of this research. It allowed participants to discuss any help-seeking strategies that they felt was relevant to their trauma recovery. Practical and safety considerations narrowed down the inclusion criteria to those participants seeking help only at the selected recruitment sites – here, a support service from a third sector organisation and a trauma service from the National Health Service. Characteristics and justifications for choosing these sites will be discussed in section 3.8. Limiting participants to certain sites ensured that they could access their home support service for care in the exceptional case that interviews triggered distress.

Furthermore, English speakers with the capacity to consent were considered eligible for this study. Due to the sensitive research topic and to ensure participants' confidentiality and anonymity, non-English speakers were excluded in order to avoid exposing a third party (e.g., a translator or interpreter) to the full interview content. Equally, the capacity to consent was an important ethical requirement. Finally, this study was open to both men and women.

3.8. Research sites

Two support services were selected which are similar in that they provide trauma-informed care, but are different in the way they provide this care. Choosing trauma-
informed services for recruitment ensured that the researcher gained access to participants who met the inclusion criteria of having a history of interpersonal trauma, and of seeking help and engaging in recovery. Choosing services that were different in their approaches of providing support was valuable because diverse recovery journeys of trauma survivors could be captured. The need for such diversity has also been highlighted by Chouliara et al. (2014) and Martsolf, Courey, Chapman, Draucker, and Mims (2006) and it fitted well with the exploratory nature of the current study. Nonetheless, Martsolf et al. (2006) argued that by using specific services to access trauma survivors implies that the study consists of a convenience sample which is not representative of the general population of adults recovering from interpersonal trauma. This limitation has been acknowledged during the research design process and, therefore, support services with different approaches were chosen to help capture at least some level of diversity.

To better understand the support environment of participating trauma survivors as well as the research setting, the similarities and differences of the clinical and community site will be presented here in more detail. This overview will also serve the reader to assess the quality of the research findings. The following comparison is based on the researcher’s observation and notes taken during her engagement with these research sites.

One research site is a clinical and statutory trauma specialist service of the National Health Service in the UK located in Scotland. The other research site is a community centre which hosts several community development projects by a third sector organisation in Scotland. Both services are similar in that they provide psycho-educational group support and individual support to adults suffering from a history of interpersonal trauma. They also tend to offer a choice in support. However, they differ in many ways.
Firstly, trauma survivors access these services in different ways. While they tend to be referred to the clinical service by other health professionals with no self-referral option, the community centre has no formal referral system and, instead, adults drop in and spend time during opening hours. In contrast to the clinical site, the community centre is also open to the public and open at weekends.

Secondly, there is a difference in the variety of cases. Health professionals at the clinical site see male and female cases exposed to any form of psychological traumatic event (i.e., patients exposed to interpersonal violence, but also to combat experiences, traumatic accidents or natural disasters). By comparison, the community centre runs multiple projects. The project of interest to the current study supports women who have experienced abuse and suffer mental health difficulties because of this.

Thirdly, the clinical and community sites differ in the way they determine trauma survivors’ difficulties and needs. After patients are referred to the clinical service they are formally assessed by a clinical team. Based on this assessment, suitable treatment options are offered to the patient. By contrast, there is no formal assessment at the community centre. Rather, community staff will have an informal conversation with an incoming person and, through this conversation, assess the person’s history, and his or her current difficulties and needs. Then, they will suggest facilities offered by the centre which may help the person address these difficulties.

Fourthly, the two research sites vary in the range of support they provide. While the clinical service specialises in formal evidence-based treatment (such as trauma-focused therapy, EMDR, or CBT-based psycho-educational programmes), the community centre provides general psychological support as well as practical help. This may range from psycho-educational group workshops, to one-to-one support, informal peer discussions, crisis support, and informal online and phone conversations as well as benefit and finance advice, accommodation advice, help dealing with statutory services (e.g., police, court, and social work), parenting
support and volunteering opportunities. Community members may access several kinds of support at the same time and as often as they need. By contrast, patients at the clinical service access only one type of treatment at any one time before being discharged or being offered another form of treatment within the service.

Fifthly, there is a difference regarding the support team. The clinical site provides treatment by specialised, highly qualified and trained clinicians, whereas the community site provides support by non-clinical staff specialised in trauma or addiction but also by peer trauma survivors, other community members, and staff knowledgeable in practical issues (e.g., benefit support).

Finally, the research sites differ with regards to discharge. Treatment in the clinical service tends to be time-limited. That is, trauma survivors are formally discharged when a group therapy programme has been completed or when trauma symptoms have decreased to an extent that the person can function again in daily life. At other times, they are referred to the service which assessed them initially. By contrast, trauma survivors access the community centre as long, as much, or as little as they wish.

Overall, the clinical site provides an end-point time-limited specialist service to which other, more general, services (e.g., general practitioner, community psychiatric nurse) refer to. While it is structured and organised, access can be denied by uninformed gatekeepers and delayed by long waiting lists. By contrast, the community centre is flexible, resulting in quick access to a range of support options. It appears to serve as a hub – a connection point to and from external services – focusing on building a long-term support network between staff and community members. However, it can appear messy and disorganised at times. And while it is equipped to address a broad range of difficulties trauma survivors may face – thus, taking a holistic approach and considering the complexity of human life – it does not offer the same expertise on trauma that the clinical site provides. Table 3 shows a summary of the differences.
Table 3

**Differences between clinical and community research sites**

<table>
<thead>
<tr>
<th>Clinical research site</th>
<th>Community research site</th>
</tr>
</thead>
<tbody>
<tr>
<td>Structured, organised, end-point</td>
<td>Disorganised, flexible, hub/network</td>
</tr>
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</table>

1. Access via referral from other health professionals acting as gatekeepers  
   Open access to community members and the public, drop in
2. Male and female patient exposed to any form of psychological traumatic events  
   Women’s project: Female survivors of abuse
3. Formal assessment by clinicians  
   Informal conversation with community staff
4. Evidence-based group treatment or individual trauma-focused therapy  
   General psychological support (to some extent, trauma- and addiction-focused), practical support
5. Specialised, qualified, trained clinicians  
   Non-clinical specialised and non-specialised staff, peer survivors, community members
6. Discharge after programme completion or when trauma symptoms decreased, occasionally re-referred to initial service  
   Membership as long or little, and as frequent or infrequent as needed; can extend beyond feeling recovered
3.9. **Study materials**

During the preparation of study materials, supervisors, a research sponsor, staff from both research sites, and potential participants at the community site gave feedback. Initially, study materials (e.g., recruitment poster, information sheet, demographic questionnaire) were the same for both research sites and had been approved as such. However, additional feedback emerged between completing data collection at the community site and beginning data collection at the clinical site. Therefore, minor changes were made to documents used at the clinical site, such as a renaming of the lay title from “Recovery journeys following abuse” (community site) to “Recovery journeys following interpersonal trauma” (clinical site). The change in title was recommended because the term ‘abuse’ may have been misunderstood at the time as referring only to *childhood sexual* abuse due to the media presence on this topic. Due to most alterations being minor, where two version exist, the appendices will only show study materials used at the clinical site, with exception of recruitment posters.

Firstly, recruitment posters were created for each research site (appendix A and B), and an advertisement for the community site’s social network page online was developed (appendix C).

Secondly, a letter of invitation (appendix D), a participant information sheet (appendix E) and consent form (appendix F), adapted from NHS ACCORD (2017, CR007 “Study document”), were developed for recruitment. These documents informed participants about the study objectives, procedure, and participants’ rights and ensured that the study adhered to ethical procedures.

Thirdly, a demographic questionnaire (appendix G) was developed which collected information of participants’ age, gender, education, employment and marital status, number of children, living circumstances, and ethnic background. The use of such a
questionnaire was adopted from Banyard and Williams (2007), Bermudez et al. (2013), Lind et al. (2014), Phanichrat and Townshend (2010) and Stige et al. (2013) to describe the group of participants that took part and helped make inferences of the quality and transferability of the study.

Fourthly, a debriefing sheet (appendix H) was created to remind participants what the study was about and to inform them of support organisation that they could contact in case they required psychological support.

Further documents used during the interview meeting included a form where participants filled in their general practitioner’s details, whether they would be willing to give feedback at a later stage, and whether they would like to receive a study summary (appendix I). The researcher also created a receipt for participants to sign and confirm that a retail vouchers was received.

Retail vouchers of £10 each from Love2Shop were given as a thank-you for individuals’ participation. The voucher also came with a card and envelope. An A4 sheet showing a list of stores where the voucher could be redeemed was also inserted into the envelope. Providing this choice to trauma survivors was regarded as important. Although it has been observed that trauma survivors participating in research feel rewarded alone by the opportunity to tell their story and help other survivors, it was felt that thanking them with a retail voucher affirms a sense of worthiness (Campbell & Adams, 2009; DePrince & Freyd, 2006; McClain & Amar, 2013).

Furthermore, a template letter to the general practitioner (appendix J) was prepared which informed participants’ general practitioner that one of their patients took part in the current study. This is in line with ethical requirements when conducting research with the UK National Health Service.
Finally, a brief research summary for participants was drafted (appendix K). This summary informed them of preliminary results from the analysis and requested their feedback.

3.10. Ethical considerations and secure data management

An important part of psychological research is participants’ safety. Potential risks may include, for example, that adult survivors of interpersonal trauma feel forced to participate, that their consent is based on insufficient information, that they could be identified by others in the reporting or sharing of data, that they become upset during and after the study, that personal and research data were accessed by unauthorised persons, and that survivors may disclose harming themselves or another person being at risk of being harm. Additionally, there may be potential risks to the researcher. These and other risk factors have been addressed in this study in the following ways:

3.10.1. Voluntary participation

Firstly, study participation was voluntary. In order to minimise any sense of compulsory involvement in this study, potential participants were identified and initially approached – not by the researcher but – by direct clinical staff (clinical population) or direct community staff (community population). Then, this direct care team recommended the present study and, where patients or community members indicated interest, signposted them to the researcher. Additionally, the researcher informed participants verbally and in writing that they may withdraw at any point during the study without having to provide a reason and without it affecting the care and support they received (The British Psychological Society, 2009; Willig, 2001). Should they decide to withdraw during the interview, it was agreed to
stop the recording and that any information collected up to this point might still be used for data analysis. In this study, no participant decided to withdraw after written informed consent was given. The researcher also informed participants that they decide how much they wish to disclose during the interview and in the subsequent questionnaire.

3.10.2. Informed consent

Secondly, before the interview, the researcher provided participants verbally and in writing with relevant information about content, procedure and purpose of the study as well as information about their rights (appendix E). Thus, the study adhered to common ethical guidelines that recommend ensuring informed consent and avoiding the deception of participants (Newman & Kaloupek, 2009; Seedat, Pienaar, Williams, & Stein, 2004; The British Psychological Society, 2009; Willig, 2001, 2008). During recruitment and shortly before giving written consent, the researcher also offered participants to ask the research team any questions that they may have about the study before participating. They could also contact an independent advisor.

3.10.3. Reducing possible distress

Thirdly, because the interview questions related to a sensitive topic, namely traumatic experiences of abuse and the recovery from subsequent trauma, it was considered that, in some cases, this may trigger troubling memories and upset some individuals (Seedat et al., 2004). However, the risk for distress was expected to be low for two reasons. Firstly, the trauma experience itself was not central in the interview; instead, participants were interviewed about the trauma consequences and the subsequent recovery process. Secondly, this was a post disclosure study. All potential participants had identified themselves as having been a victim of abuse,
had talked about their trauma experience to someone before, and were in treatment at the time or otherwise help-seeking. Previous studies have safely conducted similar interviews about the recovery of trauma survivors (Banyard & Williams, 2007; Chouliara et al., 2014; Phanichrat & Townshend, 2010).

Despite this, several procedures were put in place to minimise potential risks: This study recruited participants from support services that they used at the time and that they were familiar with. This ensured that psychological support could be accessed from that same service in case participants became distressed during and after the study. The researcher also informed participants about the potential, yet low, risk of troubling memories being triggered. If the participant or the researcher believed that high levels of distress were experienced, then participants could take short breaks until they felt ready to continue. Alternatively, the researcher provided the option to stop the interview entirely and to inform another mental health professional (clinical population) or staff member of the community (community population) for assistance. There was only one case where the participant became upset. When the person did not request a break and continued answering questions, despite showing tears over several minutes, the researcher acknowledged her distress, and let her know that she can take a break but also continue if she wished. The participant signalled to continue and, eventually, her distress subsided.

3.10.4. Anonymity, confidentiality, and disclosure of information

Fourthly, the researcher considered the required level of confidentiality and anonymity. Anonymity refers to the withholding of information, such as names, times and places (Seedat et al., 2004; The British Psychological Society, 2009). Confidentiality refers to withholding the content of conversations (Coolican, 2004). The decision of the level of data disclosure has to balance participants’ safety as well as the usefulness of the data. That is, on the one hand, a certain degree of anonymity
and confidentiality has to be ensured in order to protect the participant’s identity. On the other hand, a degree of access to participants’ personal information and content of conversations has to be granted to allow the analysis of the data and publication of results. In this respect, the Information Commissioner’s Office (2012) suggested that different information may need to be withheld depending on how much and what information is shared, and with whom.

In this study, the researcher ensured participants’ anonymity by removing any personal details (e.g., names, places) from transcripts or by replacing them with general identifiers (e.g., ‘a young parent’, instead of ‘a 23-year old mother’) before sharing them, by replacing participants’ names with a participant number, and by limiting access to documents with participants’ personal information to the main researcher only (with exception to the letter to participants’ general practitioner).

Confidentiality of conversations between participants and the main researcher in qualitative research, such as this study, cannot be fully offered (Coolican, 2004). While the audio content of the interviews was only accessible to the researcher, the complete anonymised transcript of each interview was made available to the researcher’s supervisors in order to aid data analysis. In addition, permission was obtained to publish excerpts of the anonymised transcripts because these excerpts serve as evidence of the research findings. However, excerpts that could still identify the participant based on the conversation content, even after removing personal details, will not be used in publications. The safety of participants takes priority over sharing findings. The letter to participants’ general practitioner contained their full name; no conversational content was shared with the general practitioner.

However, where the researcher had concerns for participants’ safety or for another person at risk of being harmed based on what the participant shared during the study then confidential information was disclosed to a member of the direct care team or, where unavailable, a mental health emergency contact. Participants were
informed that the researcher will discuss this with them first before information is shared in this case. During the course of data collection, there was only one incident where concerns arose, and this was raised with staff members.

Participants were fully informed to what extent anonymity and confidentiality could be granted before giving informed consent. The technical details of how data were stored and managed to ensure anonymity and confidentiality will be described next.

3.10.5. Secure data management and storage

This research generated data as hard copies and in digital format. Hard copy data included:

- audio recordings on a recorder,
- completed consent forms,
- completed demographic questionnaires,
- completed forms with general practitioner details,
- letters to general practitioners,
- printed anonymised transcripts, and
- contact details in a research phone.

With exception of letters to participants’ general practitioner, these hard copies have been stored in locked cabinets at the researcher’s university or have been kept in the researcher’s possession during use. Audio recordings were stored on an encrypted device, but were transferred to the university’s encrypted network drive as soon as possible after each interview and then deleted from the audio recorder. Participant names, telephone numbers and short message conversations on the research phone were password-protected. Letters to participants’ general practitioner were printed and sent in a sealed envelope to the relevant medical practice.
Digital personal or sensitive data included:

- participants’ contact details and assigned study number stored in a file
- audio recordings
- demographic details of participants (study number, no name) stored in a file
- digital interview transcripts
- field notes, transcript notes and analysis notes in a research diary
- general practitioner letters.

All digital documents containing this data were stored on an encrypted network drive at the University of Edinburgh. Except for the audio recordings, all these documents were also password-protected. Audio files on the secure drives could not be protected with an individual password as there was no technical feature available. Only the researcher had access to these documents, with exception of the digital anonymised transcripts which were shared with the researcher’s supervisors.

Participants were also assigned a study number which, on most documents (hard copy and digital versions), replaced participants’ names. Only the doctoral researcher had access to identifiable data. The match of study number and participant name was only kept on the consent form (which was locked separately from documents with the study number only) and in a digital file containing participants’ contact details (which was password-protected and stored on an encrypted network drive). Both documents were accessible only to the researcher.

3.10.6. Debriefing

Another ethical requirement was to debrief participants (The British Psychological Society, 2009). Therefore, the researcher invited participants to ask questions and share their interview experience after the interview. This helped identify any distress and misunderstandings, and offer clarification and support immediately. In addition,
participants received a debriefing sheet with details of emergency contacts and support organisations in case they have concerns at a later stage. They were also given full details of the research team, and information on how to raise a complaint.

3.10.7. Potential benefits

This study had no direct potential benefit to participants and this was stated on the participant information sheet. However, there has been evidence that sharing one’s recovery journey in trauma research provides a positive experience to participants (Campbell & Adams, 2009; DePrince & Freyd, 2006; Griffin, Resick, Waldrop, & Mechanic, 2003; Newman & Kaloupek, 2009; Seedat et al., 2004). Therefore, individual participants may have indirectly gained personal insight and meaning by talking about their experience in the interview. Participants were given £10 retail voucher to thank them for their time and, if they wished it, received a summary of the overall findings on completion of the project.

3.10.8. Researcher’s safety

Due to the nature of the topic, the researcher considered her own potential risk of distress. There is evidence that those working with trauma survivors may experience trauma-like symptoms when exposed to traumatic material (Arthur et al., 2013; Elwood, Mott, Lohr, & Galovski, 2011; Seys et al., 2013). In this study, the risk was thought to be low because the researcher had previous experience of working with this vulnerable group, received regular supervision from qualified Clinical Psychologists (academic supervisors) and used a reflective diary. The study was conducted at the research sites and during opening hours. Therefore, there was no risk of lone working.
3.10.9. Ethical approval

This study was approved by the NHS Research Ethics Committee of South East Scotland 01 in February 2015. This covered both, the clinical and community research site. NHS ethical approval was logged with the University of Edinburgh ethics committee.

3.11. Recruitment

3.11.1. Simultaneous vs. sequential recruitment from research sites

Before beginning to recruit, a theoretical choice had to be made in what order to recruit and interview participants from the two research sites. While, on the one hand, the aim was to regard participants from both research sites as one homogenous group of adults seeking help for interpersonal trauma, on the other hand, the possibility was considered that differences in their recovery journey may emerge depending on which research site they attended for support. If there were a difference at all, the research design had to ensure that both possibilities could be captured and research quality maintained. While there are multiple sequences in which interviews from different sites can be arranged, two options were considered:

1. to recruit from each site simultaneously as participants become available, or
2. to recruit first from one site and then from the other

Simultaneous recruitment – option one – groups participants from both research sites together. However, differences (if any) between participants’ experiences of seeking help from one site or from the other site would be less apparent. That is, distinct site-related patterns of changes in recovery would remain obscure.
Therefore, this strategy appeared less robust. By contrast, sequential recruitment – option two – distinguishes participants at each research site from the beginning. Recruiting sequentially was considered to increase the visibility of potential group differences in interview patterns. Although it also risked generating implicitly expected differences that may not be present, this risk was reduced by practicing ongoing reflexivity reminding the researcher to regard all participants as *one homogenous group* for most part of the interviewing process. The consideration of group differences was revisited during later phases of theoretical sampling and the analysis process. Therefore, sequential recruitment was chosen to begin with because it was considered more robust for both (group homogeneity or group differences) to emerge.

This recruitment strategy must not undermine the process of theoretical sampling that is characteristic to grounded theory. Theoretical sampling involves additional data collection to refine categories and their properties that have emerged from data analysis (Charmaz, 2014; Sbaraini et al., 2011; Willig, 2013). In order to refine these categories and properties, a certain flexibility is required in the recruitment strategy. In the present study, a sequential recruitment strategy served as a starting point, while alternating site recruitment was deemed feasible in later phases to allow theoretical sampling.

Table 4 shows the order of recruitment and interviewing. There were no theoretical advantages of beginning with one research site over the other. Therefore, it was decided for practical reasons (including ethical approval) to begin recruiting participants from the community site. Recruitment and interviewing took place in rounds. After two to five interviews were conducted and analysed, insights were followed up in a further round of two to five interviews. This is in line with the grounded theory method (Charmaz, 2014; Sbaraini et al., 2011). The interview process will be discussed in more detail in section 3.12.
Table 4

Order of recruitment and interviewing at the community and clinical research site

<table>
<thead>
<tr>
<th>Round</th>
<th>Number of participants, and research site</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>One</td>
<td>3 (community site)</td>
<td>May – June 2015</td>
</tr>
<tr>
<td>Two</td>
<td>2 (community site)</td>
<td>August 2015</td>
</tr>
<tr>
<td></td>
<td>1 (clinical site: pilot)</td>
<td></td>
</tr>
<tr>
<td>Three</td>
<td>2 (community site)</td>
<td>September 2015</td>
</tr>
<tr>
<td>Four</td>
<td>2 (clinical site)</td>
<td>February 2016</td>
</tr>
<tr>
<td>Five</td>
<td>5 (clinical site)</td>
<td>April – May 2016</td>
</tr>
<tr>
<td>Six</td>
<td>feedback to research summary requested,</td>
<td>March – April 2017</td>
</tr>
<tr>
<td></td>
<td>no responses</td>
<td></td>
</tr>
</tbody>
</table>

3.11.2. Screening and recruitment process

This study aimed to recruit up to 25 adults. This sample size is determined from other qualitative studies of adult survivors of childhood sexual abuse (Banyard and Williams (2007): 21 participants; Chouliara et al. (2014): 22 participants; Oaksford and Frude (2003): 11 participants).

At the community site, potential participants were identified by the community staff team who approached suitable women, recommended the study and asked them to contact the researcher for more information if they were interested. A recruitment poster was also placed on the community notice board, and an advert was posted online on the community’s social network site. Both adverts informed about the study and invited community members who met the inclusion criteria to contact the researcher directly for more information.
At the clinical site, potential participants were identified by the clinical direct care team from patient records and then approached by the care team about the study and referred to the researcher for more information. In addition, clinicians introduced the researcher to patients during or after group therapy settings where the researcher could inform group members about this study, pass on information sheets and invite them to take part. This was the more successful approach to recruitment. A poster was placed in the waiting area of this service to invite potential participants to refer themselves to the researcher.

The researcher answered any questions potential participant had before taking part, and emphasised that participants’ decision will not impact on any treatment or care they receive, and that their taking part is voluntary. Those who decided to take part met with the researcher at a mutually agreed time at the clinical service (for participants recruited from this site) or the community centre (for participants recruited from this site) to provide written consent.

3.12. Interviewing

According to Kvale (2006), interviews are often referred to as dialogues; however, this is misleading. He suggested that dialogues have egalitarian characteristics where knowledge is constructed mutually. An interview is different in that one person meets another with the purpose to receive information or to accomplish a certain goal (Kvale, 2006).

In research, three types of interviewing exist: unstructured, structured and semi-structured. Unstructured interviews use open-ended questions and no or a very basic interview question schedule, thus gaining in-depth information (Fontana & Frey, 2005). The participant is free to respond to, and expand on, the interviewer’s questions who provides little direction. That is, the interview topic may develop in
any direction. Overall, the exchange between interviewer and respondent may be more spontaneous (Holstein & Gubrium, 2003a). By contrast, the structured interview contains a clear set of questions from which the interviewer does not deviate (Brinkmann, 2013; Fontana & Frey, 2005). Answers may be limited by multiple choice options or, alternatively, may provide some space for the interviewee to respond in their own words. However, Brinkmann (2013) and Fontana and Frey (2005) suggested that the interviewer may not be able to follow up these responses in more depth, nor share their personal views. Semi-structured interviews use features of both methods. On the one hand, they are partially structured with an approximate schedule of interview questions. This has the advantage of keeping the direction of the interview focused on key aspects of the inquiry. On the other hand, semi-structured interviews allow participants to respond freely to the interviewer’s questions, and the interviewer can follow up their responses where it might deepen an understanding in relation to key aspects. For the current study, data were collected through single semi-structured interviews.

### 3.12.1. Suitability of semi-structured interviewing

Semi-structured interviewing helps foster an informal environment where participants can answer flexibly and relatively freely, where a natural flow for conversations is encouraged, and where the interviewer can follow up relevant points and maintain direction of the research topic (Coolican, 2004; Holstein & Gubrium, 2003b; Mason, 2002). According to Charmaz (2014) and Holstein and Gubrium (2003b), such intensive and partially structured interviewing will produce a rich and in-depth account of adults’ experience of trauma recovery, which is essential for developing and refining a robust theory. Similarly, Holstein and Gubrium (2003b) suggested that this technique can tap into individuals’ subjective world – such as experiences of trauma recovery – and allows the interviewer to pursue any emerging ideas and questions right there and then and is compatible
with grounded theory method (Charmaz, 2014; Holstein & Gubrium, 2003b; Willig, 2008). In other words, interviewing provides the flexibility for theory building by allowing the researcher to generate nuanced, complex and rounded data, to direct the questions towards emerging topics and then focus on these topics to collect specific data, and to explore the ways in which participants perceive and interact with their environment (Holstein & Gubrium, 2003b; Mason, 2002).

However, there are three key concerns with using interviews for collecting data. Firstly, data obtained from interviews were limited to what is spoken in the interaction between researcher and participant (Willig, 2008). That is, interviews do not tend to collect contextual information surrounding the interview, nor do they include observations of how participants interact with other people around them. Secondly, interviewing is also limited in that it can only collect information that speakers choose to put into words or utterances, or that they enact or remember (Mason, 2002). In order to try to address these concerns, the researcher took reflective notes which documented her perception of the research sites and of interactions with participants, as well as of any non-verbal information (e.g., body language) remembered while transcribing the interview. Such records bear similarities to participant observations (Willig, 2008), or field notes in ethnographic studies (Kawulich, 2005; Wolfinger, 2002), or memos as used in the grounded theory method itself (Charmaz, 2014). For this study, these notes formed a research diary which will be discussed in more detail in section 3.14. Coolican (2004) has also expressed concern that the flexibility of interview formats results in less consistent, less reliable and less comparable responses. However, consistency, reliability and comparability have not to be ensured in the same way in qualitative studies as in quantitative studies. Instead, interviews in qualitative studies wish to discover inconsistencies, surprises and differences that are unique to individuals (e.g. as in IPA) or that show variations of experiences in a specific group (e.g. as in grounded theory).
3.12.2. Practice interviews

Interviewing requires thorough preparation about participant choice, recruitment procedure, interview recording, transcription, interview style and interview questions (e.g., Mason, 2002; Ritchie & Lewis, 2003; Willig, 2008). Charmaz (2014) and Goodrum and Keys (2007) suggested practicing interview techniques, particularly where emotional topics are to be discussed. Practice interviews for the current study were conducted in January and February 2015 with acquaintances of the researcher. This process helped testing out recording equipment, interview procedure and different interview strategies. Interview questions for this practice were not around intense trauma experiences of these acquaintances. Instead, the interviews explored their experience of common life changes, such as moving to a new place, beginning or ending a relationship, or beginning a new job. In this way, practice interviews protected respondents from upsetting material.

3.12.3. Interview procedure before, during, and after the interview

When meeting with participants the following procedure was applied: Participants met with the researcher for a session of about 1.5 hours. At the beginning of each session, participants were reminded about the study topic, the procedure, purpose and participants’ rights. The researcher asked a few follow up questions to evaluate participants’ understanding and their informed consent (Becker-Blease, 2007). It also had the additional advantage that participant and researcher began a dialogue and found their voice as a warm up for the interview. Then, the researcher invited participants to ask questions, and obtained consent. The recorder was started and the interview began with questions relating to the research topic and any follow-up questions for clarity. In three cases the interview and the audio recorder were paused for a short break and then restarted. After the final question, the audio recorder was stopped. Participants completed a short demographic questionnaire,
and were debriefed, given information of support contacts and invited to provide informal feedback about their interview experience. As part of ethical procedures, the researcher requested participants’ general practitioner details. Then, the researcher asked whether participants would volunteer to give additional feedback on key themes and questions, and whether they would wish to receive a research summary after the study was completed. All participants allowed the researcher to contact them again for feedback, and all wished to receive a summary. Finally, participants received a £10 retail voucher as a thank-you.

3.12.4. Structure of the interview, and interview questions

During the interview, participants were asked about their recovery journey and how they managed early and present experiences, with a focus on managing feelings and relationships with others. The first part comprised opening questions that are descriptive and general in nature, such as “Tell me what had happened that brought you to this service?” This open and broad approach at the beginning allowed participants to tell their story and influence the direction within the topic of trauma recovery context (Brinkmann, 2013; Charmaz, 2014). Thus, the researcher minimised imposing her assumptions on answers.

The middle part asked for experiences in depth. This included questions on how participants dealt with the repercussions of having experienced traumatic events, what helped improve their life because of trauma, and how emotional and interpersonal experiences were managed. Adhering to the grounded theory method, the researcher asked participants to describe in detail and give examples (Charmaz, 2014). These details and examples generated rich narratives and avoided generic answers. The researcher also enquired about process with questions, such as “What was it like for you at the time?”, “What happened just before?”, or “What happened next?” However, the researcher directed away when conversations became
dominated by talk of initial trauma events and day-to-day difficulties and, instead, redirected attention on conversations of recovery.

The final part ended with questions that indicated closing, such as “Is there any advice that you would give to other survivors to help their recovery?” (Phanichrat & Townshend, 2010, p. 67) or “Is there something else you think I should know to understand trauma recovery better?” (Charmaz, 2014, p. 67). Structuring the interview in this way has been considered useful by Charmaz (2006), Coolican (2004), Fontana and Frey (2005), Kvale (1996) and Rubin and Rubin (2012). Follow-up questions were asked throughout the interview. These invited interviewees to share and explain their story in more detail while they also enabled the researcher to test her understanding of the responses (Brinkmann, 2013; Kvale, 1996). Charmaz’s (2014) examples of interview questions and the Critical Interview Schedule (cited in Chouliara et al., 2014) served as a guide.

3.12.5. Interviewing in rounds

Interviews were conducted in five rounds, with two to five interviews in each round. This is consistent with grounded theory where data in previous rounds are tested and refined in subsequent rounds (Charmaz, 2014). As a result, the kind of questions the interviewer asked changed. To illustrate this, in the first two rounds the interview followed an open and broad schedule. Where the researcher noticed topics reappearing in subsequent interviews, she probed participants on different aspects of such topics. For example, conversations indicated perspective changes, gaining knowledge, and forward-backward-forward developments of recovery. These were followed up. However, the researcher did not impose these questions where participants have not initiated conversations of these topics during these early interview phases.
In subsequent rounds, questions remained open and flexible to allow new recovery aspects to surface. However, because central topics began to crystallise from earlier interviews and from initial and focused coding, the researcher used increasingly more focused questions whenever (and only when) participants initiated these topics. For example, the researcher identified multiple emotional experiences around anxiety, sadness, confusion and frustration in earlier interviews, but few talked of anger or joy. Whereas in early interview phases the researcher might have skipped and overlooked these aspects of recovery, in round three and four these aspects where intentionally sought out (but not forcibly created) and, when the participant mentioned them, they were followed up.

In the final interview round, interview questions tended to focus mainly on specific topics, questions and gaps identified during focused and theoretical coding (Charmaz, 2014). Therefore, conversations were less directed by participants and increasingly guided by the interviewer. Focused questions ensured that key concepts developed during analysis could be tested and refined. In this study, the final round was complicated by tightly scheduled interviews. As a result, analysis of previous interview material in that round was still ongoing during the following interviews and, thus, specific questions, gaps and uncertainties had not yet clearly crystallise to follow them up in subsequent interviews. However, refinement of key concepts was not compromised by this because these interviews elicited rich descriptions and multiple examples nonetheless.

3.13. Achieving quality

Ensuring the quality of this research is important. Quality has been achieved by applying consistent sampling and transcription methods, by practising interviewing techniques in pilot studies and by receiving adequate training in analysis and software use. Regarding the latter, the researcher completed a BSc programme in
Psychology and an MSc programme in Psychological Research Methods. These programmes included training and practice in conducting psychological research. In particular for the current study, the researcher also attended specialist courses on Conducting Research Interviews, Analysing Qualitative Data, using NVivo, suicide awareness training (safeTALK), Working with Sensitive Data, and working with trauma survivors (Safe to Say). However, there are broader issue of how rigor and trustworthiness is achieved.

In quantitative research, quality typically concerns validity, generalisability and reliability. However, debates have emerged as to what extent these criteria are suitable to assess qualitative studies. Rolfe (2006) highlighted three positions: (1) researchers who judge qualitative research using quantitative criteria, such as validity, generalisability and reliability (e.g., Long & Johnson, 2000), (2) researchers who adopt new terms and criteria to assess quality of qualitative studies, such as credibility, transferability, dependability, importance of fit, and originality (e.g., Charmaz, 2014; Guba & Lincoln, 1994; Henwood & Pidgeon, 1992; Trochim, 2006), and (3) researchers who argue that the same set of criteria cannot be applied to all qualitative research and, instead, each qualitative study with a distinct method requires its own criteria to assess quality (Rolfe, 2006).

Qualitative methods lie on a realist vs relativist spectrum and, therefore, adopt quality criteria that include either more realist or relativist features (Willig, 2013). Constructivist grounded theory follows a position closer to the relativist end of the spectrum. It is less clear what quality criteria to adopt in this case. Charmaz (2014), for instance, suggested originality, resonance and usefulness as criteria, and offered a set of questions to assess these. While this is useful, these criteria appear to cover only some aspects of quality and do not indicate to what extent they correspond with or deviate from more realist criteria. What follows for this study is that alternative terms will be adopted, such as credibility, transferability and
dependability. However, because they are useful only to a certain degree, other quality criteria will also be considered.

3.13.1. Credibility

Credibility is considered similar to validity (Long & Johnson, 2000). Research is considered credible or valid if a logical conclusion can be drawn from the tools used to investigate the research question and from the results obtained to answer this question (Mann, 2003). According to Long and Johnson (2000), Leavy and Saldaña (2014) and Willig (2013), clear and rich description and persuasive justification increase the credibility of a piece of scientific work. The present study aimed to achieve credibility (1) by stating a clear research question at the beginning, (2) by laying open to the reader what data have been collected, how and from where, and by justifying that the kind of data and collection procedure is appropriate in answering the research question, (3) by disclosing what procedure was used to analyse the obtained data, and justifying its suitability, and (4) by describing and interpreting the findings. Additional methods in this study included documenting the actual procedure, decisions, and field observations throughout the data collection and analysis process in a research diary. This left an audit trail that can be scrutinised (Onwuegbuzie & Leech, 2007). Journal-keeping also aided the researcher in reflexivity and left a trail of the researcher’s reflections on her assumptions, beliefs and values that may have shaped the findings. Although the researcher requested feedback on the results from participants to assess validity (Leavy & Saldaña, 2014; Long & Johnson, 2000; Onwuegbuzie & Leech, 2007), unfortunately no participant responded. However, the researcher regularly checked procedures with academic supervisors – a form of peer briefing to check quality (Long & Johnson, 2000; Onwuegbuzie & Leech, 2007).
Furthermore, credibility was ensured by triangulation involving several methods to cross-check results. For example, codes and categories have been continuously and consistently cross-check throughout all interviews. Codes and categories that consistently repeated indicated that participants agreed on a topic. This demonstrated credibility (Guion, Diehl, & McDonald, 2011; Long & Johnson, 2000). Similarly, the researcher cross-checked results with external literature and research findings and with recorded field observations and non-verbal information, thus, adding validity. Credibility was also achieved by identifying and following up inconsistencies, negative cases, extreme cases and surprises. Charmaz (2014), Long and Johnson (2000), Onwuegbuzie and Leech (2007), and Willig (2013) have suggested that these forms of triangulation are suitable ways to add trustworthiness to a qualitative study.

Finally, Leavy and Saldaña (2014) and Willig (2013) suggested that providing examples of how data collection and analysis were conducted, of quotes of participant interviews, and of excerpts from field notes adds credibility. For this study, the researcher aimed to provide examples throughout this piece of work.

3.13.2. Transferability

Transferability tends to be equated with generalisability (Long & Johnson, 2000). Research is considered transferable if study results can be applied to populations or settings outside the specific sample and research context from which data were produced (Willig, 2013). Qualitative research results are often assumed to not be representative of a population or a wider setting, and therefore deemed not generalisable. However, Trochim (2006) suggested that it can be transferred with caution to some degree. Transferability can be improved by carefully describing the sample, research context and core assumptions. Detailed descriptions of these have
been provided in this chapter. This allows other researchers to make an informed decision whether findings can be transferred to other settings.

The criterion of transferability bears resemblance with Charmaz’s (2014) criteria of ‘usefulness’. For a grounded theory study to be useful, the researcher is required to demonstrate that categories indicate ‘generic processes’, that findings might influence research in other areas, and that results are valuable to people’s lives, and contribute to knowledge and positive change in society. Indeed, findings of the present study have revealed generic processes and, therefore, are deemed useful. To what extend this is the case, will be discussed in more detail in chapter five.

3.13.3. Dependability

Dependability corresponds to the concept of reliability and refers to having “confidence in data collection” (Long & Johnson, 2000, p. 30). In other words, dependable or reliable research “ensure[s] that data collection is undertaken in a consistent manner free from undue variation” (Long & Johnson, 2000, p. 31) and, thus, would produce the same outcomes if the study were repeated. The idea of reliable qualitative research contrasts the more conventional view that reliability is incompatible with qualitative research because the constructed and subjective properties would prevent repeated studies from generating the same results (Sandelowski, 1993; Willig, 2001). With regards to interviewing procedures, dependability could be enhanced in the traditional way by asking all participants identical core questions, by staying with the research topic and by repeating some questions in a different format. According to Long and Johnson (2000), consistent answers would indicate greater reliability. This applies well to questionnaires and structured interviews.
The current study attempts to achieve dependability to a certain extent, for example, by directing interview conversations towards topics that might help answer the research question. However, the dynamic of semi-structured interviews does not allow controlling every aspect of a conversation. Also, the developing and changing interview schedule of a grounded theory study does not permit asking the same questions from the first and to the latter interviews. Therefore, questions have not been phrased completely identical, and particularly follow-up questions have differed across interviews.

Despite such complexity of judging rigor, Long and Johnson (2000) and Willig (2013) suggested two methods by which the qualitative researcher can demonstrate, not necessarily that but, to what extent he or she employed consistent procedures for data collection. Firstly, documenting in detail the actual steps and decisions undertaken during data collection and analysis reveals the degree of consistency. As mentioned previously, in this study the researcher left an audit trail of her work in a comprehensive research diary, and these notes aided her in presenting detailed evidence of processes and decisions during this study for the current piece of writing. Secondly, acknowledging the influence of the researcher on shaping recruitment, interviewing, observations, transcription and data analysis would reveal the degree of consistency. Again, the research diary of this study aided the researcher to identify and reflect on the impact of her assumptions, decisions, beliefs and values.

It appears that the dynamic and interpretative processes inherent in qualitative research make it more difficult to judge the quality of such studies than may be the case for quantitative studies. Nonetheless, as has been discussed, there are methods to determine rigor and trustworthiness. The researcher’s task is to provide a detailed honest account of method and analysis to enable the reader as best as possible to make an informed judgment; however, the final decision lies with the
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reader to what degree the given account convinces of the quality (Engward & Davis, 2015; Leavy & Saldaña, 2014; Ortlipp, 2008; Willig, 2013).

3.14. Reflexivity and using a research diary

A qualitative researcher observes and engages with social phenomena (Engward & Davis, 2015). Gergen and Gergen (2000) suggested that these phenomena are situated in a historical, cultural, geographical and personal context. In the present study, social aspects included, for example, engagement with participants, research sites and their staff and gate keepers, as well as interview conversations, the researchers’ experience in professional and personal settings, a Western ideology and British culture, past and current feminist movements, and government agendas to mental health. What the researcher of this study observed, identified and interpreted – or failed to or decided not to observe, identify or interpret – will have influenced data collection, data analysis, and the research findings. It is acknowledged that, in qualitative research, the researcher actively participates in, and is part of, the research process (Charmaz, 2014; Engward & Davis, 2015; Long & Johnson, 2000; Nadin & Cassell, 2006; Willig, 2013). Thus, the qualitative researcher cannot take an entirely neutral and objective stance. Instead, an element of subjectivity in qualitative research cannot be avoided – it is expected (Ortlipp, 2008). Where these subjective influences remain undetected or undisclosed, however, readers cannot determine what assumptions, decisions, beliefs, values and experiences may have influenced the research process and the findings. As a result, a qualitative study may appear unsubstantiated, biased and poor quality. For a grounded theory study this may result in a theory distorted by the researcher’s assumptions. When using an objectivist grounded theory approach, such assumptions have to be identified and removed (or, at least, minimised). However, constructivists embed the researcher’s experience in the process (Charmaz, 2014;
Willig, 2013). In any case, it is essential that grounded theory studies avoid accusations of poor research quality.

3.14.1. Reflection and reflexivity

This can be accomplished through the practices of reflection and reflexivity. According to Bolton (2010, p. 13), “[r]eflection is learning and developing through examining what we think happened on any occasion, and how we think others perceived the event and us, opening our practice to scrutiny by others, and studying data and texts from the wider sphere.” An example from the current study may be the researcher’s recorded observation of a participant who seemed to contradict herself: Firstly, she stated convincingly that a failed relationship was her fault. However, shortly afterwards, she assigned fault to the ex-partner for having been abusive. The researcher reflected that the participant may have wanted to appear as if protecting the other person in order to appear good in front of the researcher or, alternatively, that the participant may have learned to find fault first in herself, but then reminded herself of the other’s abuse as the source of relationship failure.

Reflexive practice, however, goes deeper. In reflexive practice, the researcher’s or society’s values, beliefs, assumptions, and experiences – which underlie those reflections – are identified and scrutinised (Bolton, 2010; Engward & Davis, 2015). With regards to the previous example of the current study, there are multiple ways to be reflexive. Firstly, the participant’s attempt to look good could be interpreted as an indicator of a power imbalance between researcher and participant. Secondly, one might interpret that by emphasising the other person’s innocence the participant perhaps attempted to deflect from her own role. There was a silence about being innocent or being at fault herself, and this could be interpreted as avoiding responsibility. Thirdly, presenting the ex-partner as initially innocent could be interpreted as part of a patriarchal upbringing that may have taught her to
assign fault to herself and deny abuse by men. Finally, the contradiction could have been perceived by the researcher by mistake and, instead, may have been the result of a poorly articulated change of mind by the participant. Such reflexive thinking requires a great degree of self-awareness (Bolton, 2010; Engward & Davis, 2015). It also prompts the researcher to act because the suggested power imbalance could be addressed in subsequent interviews or could be investigated further for patterns in all interviews; the silence or patriarchal assumption could be enquired about in other parts of the same transcript or in subsequent interviews; or the mistaken contradiction could be prevented by listening better and asking for clarification during the interview.

Through reflexivity several goals are achieved. Firstly, it enhances rigour and credibility by making the research process visible. Secondly, it increases trustworthiness by revealing the researcher’s assumptions, decisions and experiences that may have altered the research process and the findings. Since subjective influences cannot be controlled for or eliminated, and such control may even be counterproductive, practising reflexivity offers transparency and accountability (Engward & Davis, 2015; Ortlipp, 2008). Thirdly, reflexive practice reveals the limitations of a study (Engward & Davis, 2015). Overall, reflexivity achieves research quality.

Engward and Davis (2015), Lamb (2013) and Nadin and Cassell (2006) warn that reflexivity is sometimes mistaken as self-indulgent self-disclosure whereby researchers disclose their own experience extensively. However, by doing so, such disclosure would dismiss how the researcher’s experience forms assumptions and how these assumptions might have influenced the research process and the findings. A practical model of how to be reflexive has been proposed by Alvesson and Skolberg (2009). They suggest four levels. These include scrutinising
(1) how data were collected and how the researcher may have shaped sampling, recruitment, study material, and data collection process,

(2) how the researcher interpreted, reflected on and asked questions of the data during analysis, and what assumptions influenced this interpretative process,

(3) how the cultural, historical, political, ideological context and power relationships may have shaped data collection, data analysis, data reporting and use of the findings, and

(4) how language and presentation style may influence how findings, the researcher, participants and other aspects are perceived by an audience.

These aspects have been addressed in various sections throughout this piece of work.

3.14.2. Use of a research diary

Using a research diary is often recommended as a tool to aid reflexivity and in establishing credibility (e.g., Charmaz, 2014). However, only few authors examine how this can be achieved in practice (Borg, 2001; Burgess, 1981; Lamb, 2013; Nadin & Cassell, 2006; Ortlipp, 2008). Regarding reflection and reflexivity, Bolton (2010) suggested that, through the writing process, one can reflect on – and identify and document – what is going on, what he or she thinks is going on, and how events and people are perceived. For example, the researcher can record in a diary what happened, what action was taken by him or her or others, what was decided, what was said, what was felt, and how these actions, words, decisions and feelings may have been interpreted by the researcher and by others (e.g., the participants) (Bolton, 2010; Borg, 2001; Charmaz, 2014; Ortlipp, 2008). In addition, through the writing process, the researcher can be reflexive on – that is, question and scrutinise – what lies behind these actions, decisions, words, feelings and perceptions. In other words, writing becomes a method of inquiry (Ortlipp, 2008) and the research diary
becomes a tool in which values, beliefs, assumptions, habits, goals, and opinions that are surfacing during this inquiry are made visible (Engward & Davis, 2015; Nadin & Cassell, 2006; Ortlipp, 2008). This written inspection captures the variety of influences that affect the process and interpretation of a study (Nadin & Cassell, 2006).

With regards to establishing credibility, the researcher can capture methodological and interpretative changes and developments that shaped the findings and theory throughout the project. It leaves a ‘research trail’ (Ortlipp, 2008). Articulating in writing how methodology, findings and theory develop helps not only to make informed decisions, but also to justify those and provide evidence of the process and the results. Thus, using a research diary in these ways adds transparency and validity, and increases trustworthiness in the research process (Ortlipp, 2008). What is more, a research diary is also useful for showing how the researcher learns, and builds research experience (Borg, 2001; Lamb, 2013; Nadin & Cassell, 2006).

In the present study, the researcher used a research diary. This diary chronologically documented multiple aspects related to the study. It included:

- notes of the recruitment process (e.g., recruitment strategy and changes, general progress, the researcher’s learning)
- notes from field observations at recruitment sites and when with participants
- notes taken when transcribing (e.g., ideas, spontaneous insights, impression of tone of voice, and assumptions)
- notes taken when coding and categorising data (e.g., ideas, surprises, potential patterns, questions for follow up) and their process (e.g., creating, labelling, changing of categories and justifications)
- notes taken when developing theory (e.g., which theoretical categories were chosen and why, and their connections) and its process (e.g., mind maps that showed progress, justifications for changing earlier theoretical frameworks)
‒ the researcher’s learning experience with regards to recruitment, field work, and analysis
‒ summaries from meetings relevant to this study (e.g., supervision)
‒ diagrams, pictures, mind maps, and tables
‒ notes from readings (e.g., ‘how-to’s, suggested literature)
‒ ideas (e.g., for future research or publications)
‒ notes of time taken to transcribe, code and categorise
‒ questions to explore, answer and structure information

Charmaz (2014) and Flick (2009) referred to keeping these kinds of notes as memo-writing which is an integral part of grounded theory. According to Flick (2009), there are four broad categories that help distinguish between notes of (1) observations of the field, (2) the research process and methodological changes, (2) analytical interpretations and theory development, and (4) personal notes. Notes in this study’s research diary fit into these categories. However, not all notes in this study’s diary may be considered as ‘memo’. Charmaz (2014) distinguished between operational, coding and analytic memos, and this suggests that memos only capture what is directly relevant during data analysis. Yet, the current diary has captured additional notes, such as suggested reading to follow up, time keeping, or the researcher’s learning experience. Therefore, it should not be strictly equated with memos and memo-writing, albeit it does contain memos.

Notes were often taken immediately (for example, while transcribing or coding) or shortly after an occurrence (for example, when returning from an interview) while it was still fresh in the mind. This has been recommended by Charmaz (2014). She also suggested using an informal writing style intended for personal use because it frees up one’s thinking. Contrary to Lamb’s (2013) suggestions, taking research notes was not scheduled or rigidly structured. This avoided the writing to become a forced activity, which may have stifled the free writing process. Most information was kept in one large Word document, and occasionally a notebook when out and about. In
order to keep an overview and be able to search for entries easily, the diary was loosely structured with headings of key topics. These topics comprised recruitment, interviewing, field notes, personal notes, coding, transcribing, analysis, and general. In addition, subheadings and dates specified these headings. Figure 1 shows an example. The first record was taken in January 2014 while the research design was developed and before recruitment began. While entries occurred only occasionally in the first few months, they became more frequent during data collection and analysis where entries occurred almost daily.

**Coding | Interview 02**

29.09.2015

Emotional reactions from others made it ‘unsafe to say’

She spoke to professionals about the sexual assault and [...]. They showed shock. It sounded like it put her off from telling about this again. But this would stop her from seeking help and from resolving this experience. I think it’s difficult to find the balance as professional. They probably just showed a genuine reaction ...

*Figure 1. Example of organising notes in research diary (some aspects of excerpts deleted to ensure anonymity)*

In addition, this research diary is treated as a confidential document because some entries contain sensitive personal information, such as from field observations, quotes from participants, the researcher’s personal experiences, and summaries of meetings with professionals or conversations with colleagues. Therefore, the complete diary cannot be made available for scrutiny, has been password-protected, and kept on secure drives for access by the principal researcher only. Protecting anonymity took priority. However, the researcher presents selected excerpts in this piece of work to illustrate the research process.
Finally, the research dairy served as a memory aid of the research process. Similar to Ortlipp’s (2008) research experience, the researcher of the current study consulted the diary frequently during the write-up process, and diary entries assisted in identifying key points of this research and for this piece of writing. As a result, the researcher can present a transparent research process, make visible assumptions, decisions and interpretations that shape the research findings and can, thus, establish credibility.

3.15. Data analysis

Data were analysed using the full, as opposed to the abbreviated, version of grounded theory. This implies that, in addition to the original data from the interviews, the researcher also draws on other types of data, such as field observations, member checking, and academic literature. Including additional sources assists in refining the developing concepts for a more robust theory (Charmaz, 2014; Glaser, 1992; Willig, 2013). In line with grounded theory, data were analysed in parallel with data collection. Therefore, interviews were transcribed, transcripts were coded, and codes were categorised immediately while the next round of interviews was prepared and conducted. This cyclical process continued until interview round five was completed. Data analysis using constructivist grounded theory follows a set steps. This study followed Charmaz’s (2014) procedure and involved:

1) Transcribing interviews
2) Initial line-by-line coding
3) Focused coding
4) Theoretical sampling, and saturation
5) Theoretical coding and theory development
Alongside each of these steps, the researcher wrote memos and constantly compared data. This section will explain these two practices first, before presenting the theoretical and practical aspects of steps one to five. Then, when showing how steps one to five were applied in this study, these subsequent sections will also show how memo-writing and constant comparison contributed in practice to the progress of each step.

The computer-assisted qualitative data analysis software QSR Nvivo (version 10 and 11) was used to manage the data. This involved, for instance, marking text, creating codes and categories, organising these, commenting on these, searching and sorting through them, interrogating the data set, and tracking the process (Silver & Lewins, 2014).

3.15.1. Memo-writing

Writing memos captures the researcher’s thoughts about the data and research process, helps compare data to identify similarities and differences, identifies possible connections in the data, and questions data in memos (Charmaz, 2014). Through the writing process, thoughts, processes, assumptions, values and experiences become visible and can be scrutinised. The researcher develops a written record or research trail of the constructed theory (Ortlipp, 2008; Willig, 2013). For Charmaz (2014), memo-writing ensures that the researcher stays involved and close to the data, and it enables him or her to move from a descriptive to an abstract level of analysis. According to Rich (2012) and Willig (2013), memos may contain models, diagrams, matrices, and other visual tools which can aid to identify patterns and topics in the data. What memo-writing looks like practically will depend on the step of analysis and the specific issues the researcher grapples with at the time.
For the current study, memos were written throughout the research project, and used informal language. Ideas were recorded immediately or as soon as possible afterwards, and memos were kept in a type of ‘memo bank’ (i.e., the research diary) as suggested by Charmaz (2014) and Sbaraini et al. (2011). Because the content of memo-writing depends on the step of the analysis, around which the researcher develops his or her thinking, specific aspects of memo-writing adopted in the present study will be revisited under steps one to five.

3.15.2. Constant comparison

According to Charmaz (2014, p. 342), constant comparison is an “inductive process of comparing data with data, data with code, code with code, code with category, category with category, and category with concept” throughout the analysis. Eventually, the theoretical categories are compared with relevant academic literature. This practice of constant comparison assists in identifying similarities among data, initial codes, focused codes, categories and theoretical concepts, as well as differences between these and, as a result, uncovers the properties and the variety of emerging categories (Charmaz, 2014; Willig, 2013). Willig (2013) observed that this ‘moving back and forth’ does not only unite codes under larger units of meaning (the categories) but also breaks down these categories into smaller parts (the subcategories) to establish nuances within. This constant comparison is made explicit when recording one’s observations in memos. Similar to memo-writing, what is compared depends on the step of the analysis. Therefore, how comparisons were conducted throughout this analysis will be reported under each step one to five separately.
3.15.3. Transcribing interviews

The first step of the analysis involved transcribing the audio recording. Transcribing involves converting audio (or video or image) recordings into written text (Evers, 2011). According to Evers (2011) and Clayman and Gills (2004) transcribing allows the researcher to produce a verbatim record of what participants express (an advantage over previous practices of note taking), allows to visualise verbal and non-verbal expressions and to organise interactions, and allows to search and highlight the data with word processing or qualitative data analysis software. Evers (2011) also argued that, where transcribing is completed by the researcher, it becomes part of the analytic and reflective process because transcribing begins to raise awareness of what is said and what else is going on in the data. Thus, thoughtful transcription can increase the quality of the analysis, and the credibility and reliability of the findings.

Transcription process and quality

According to Bailey (2008), Lapadat and Lindsay (1999), Markle, West, and Rich (2011), Ross (2010), and Tilley (2003), transcription appears to be considered widely as a straightforward and unproblematic task, judging this on the marginal mentioning of it in reports of qualitative studies in journals and in literature on qualitative methodologies. However, the authors asserted that this view is problematic because it suggests that transcriptions are a true account of an observation or an interaction, and it fails to reveal the multiple ways that a piece of recording could be transcribed. Instead of regarding transcription as a true reflection of participants’ experience and of the participant-researcher interaction, Bailey (2008) proposed that a transcription constructs these experiences by reducing it (e.g., from real life experience to audio to text), by interpreting it (e.g., distinguishing ‘emotion’ from ‘the motion’) and representing it (e.g., a sigh as ‘phew!’). This implies that researchers make choices about what information in the recording to transcribe, and how to transcribe it. For example, transcriptions may or
may not contain tone, inflections, repetitions, incomplete sentences, fillers and slips of the tongue, pauses, hesitations, and body language (Bailey, 2008; Lapadat & Lindsay, 1999; Markle et al., 2011). Transcribing not only what is said but also how it is said can profoundly change the meaning of participants’ experience and of the participant-researcher interaction.

While the text-based record of face-to-face interviews in the present study can never be an authentic version of the original interaction (Evers, 2011; Markle et al., 2011), measures were taken to increase accuracy and trustworthiness: Firstly, each interview was converted from audio to text format by the researcher (and interviewer) soon after meeting participants. This timely processing by the interviewer-researcher ensured that non-verbal interaction was still remembered and could be recorded. It is important not to lose such information for this study as it might contain emotional content (Markle et al., 2011) that could help answer the research question. Secondly, the recording was repeatedly listened to in order to ensure that words and non-verbal information were understood and converted as accurately as was possible. Simultaneously, the researcher began to familiarise herself with the material by taking notes in the research diary of initial thoughts and observations that emerged while listening and processing the audio recording. These are common recommendations by qualitative researchers (Bailey, 2008; Markle et al., 2011). Thirdly, care was taken to record the process of how interview recordings were transcribed, what was transcribed, and why. Such detailed recording provides a useful trail to scrutinise the transcription process and the transcription itself (Markle et al., 2011).

**Adopted transcription practices**

Transcribing is an interpretative process and, therefore, requires careful consideration over the level of detail the transcribed piece should contain (Bailey, 2008; Tilley, 2003). This study uses constructivist grounded theory, where constructing meaning of the content is a core feature (Charmaz, 2014). Thus, it is considered important that
accurate meaning is reflected in the written representation of the recorded interview. This implies that just recording spoken words verbatim is not sufficient, but that additional, and perhaps subtler, information needs to be recorded. Literature has lacked guidance on what type of unspoken information should and should not be transcribed when using, in particular, constructivist grounded theory. Therefore, transcription for the present study relied on guides for qualitative methods more generally, and on the researcher’s judgement.

There are different levels of transcriptions. Evers (2011) discussed pragmatic transcription, the Jeffersonian transcription, and the Gisted transcription. In the current study, a pragmatic format was applied which means that a tailored transcription format was used that suits the needs of this constructivist grounded theory study on trauma recovery. Speech was transcribed verbatim (i.e., exact), but not every utterance or non-verbal expression was recorded. These were limited to aspects that would assist answering the research question, and occasionally limited to improve readability.

Eight practices were adopted in the present study: Firstly, transcripts included long pauses to help detect moments of thoughts, reflections, hesitations, or changes in ideas. Secondly, participants’ regional accent was documented initially, but disregarded in later transcripts as the accent itself did not appear to change the constructed meaning and only hindered readability. Thirdly, transcripts also captured when participants laughed, clapped hands, sighed, took a deep breath in or out, cried, reached for a tissue and other actions that were not expressed in language, but indicated emotional experiences related to talking about trauma and subsequent coping. Fourthly, transcripts included incomplete sentences and slips of the tongue because these indicated participants’ reflection, changing thoughts, and considerations about how to present their experience to another person. Occasionally, incomplete sentences were omitted where either they did not concern talk relating to the research topic, or they occurred very frequently. This measure was taken to
improve readability (Bailey, 2008). Fifthly, transcripts captured changes in tone of voice where it indicated emotional expressions about a trauma- or recovery-related experiences. Tone of voice was omitted from transcripts when minor changes in tone did not appear to suggest a meaningful interpretation of aspects of their recovery experience, and when frequent changes in tone of voice throughout the interview suggested typical characteristics of the person rather than of their experience of trauma recovery. Sixthly, transcripts included repetitions and fillers (such as ‘You know’ or ‘Do you know what I mean?’) in the early stages. However, some of these were dismissed in later interviews as familiarity of the material increased, and where too many repetitions impaired readability. Seventhly, overlapping speech was recorded because it indicated where participants were keen to keep talking, where participants assumed the researcher’s question, or where participant and researcher appeared to share an understanding. Finally, transcripts sometimes included brief explanations by the researcher where the text itself contained ambiguities and may lead to misunderstandings. Table 5 shows the transcription symbols used.

Table 5

<table>
<thead>
<tr>
<th>Symbols used in transcripts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transcription symbol</td>
</tr>
<tr>
<td>[ ]</td>
</tr>
<tr>
<td><em>italic</em></td>
</tr>
<tr>
<td>(word), (?), ( )</td>
</tr>
<tr>
<td>((laughs/nods))</td>
</tr>
<tr>
<td>, ;</td>
</tr>
<tr>
<td>word ; word</td>
</tr>
<tr>
<td>... ((pause))</td>
</tr>
<tr>
<td>(1:00)</td>
</tr>
<tr>
<td>&lt; word &gt;</td>
</tr>
</tbody>
</table>
Simultaneous transcribing and memo-writing

During transcription, the researcher recorded initial insights and observations in bullet point style in her research diary. This included, for example, brief comments on how words were used, and speculations of why they were used this way (example 1 in Figure 2), on critical questions that begin to check for assumptions (example 2 in Figure 2), on similar topics observed in other interviews (early constant comparison) (example 3 in Figure 2), on resolving interview dynamics (example 4 in Figure 2), and changes in tone of voice (example 5 in Figure 2). Later, during coding, some of these insights jumped out again and prompted the researcher to elaborate on topics in paragraphs. This developed the thinking around initial observations.

(1) she kept saying “practically” several times; in what way is it practical? Or what is this word achieving for her? Is it a filler? Is it an attempt to gain credibility? (05.08.2015)

(2) “I can’t explain it and that’s part of the problem” Q: Are we leaving it too much to the survivor to explain [to] us? It seems like they CANNOT explain it. They don’t seem to know in what words to put it, cannot name it. I wonder if we put too much responsibility and pressure on them to communicate their stuff to us. (07.08.2015)

(3) “But now I’m starting to know why. And it seems to have taken the power out of it so much, just understanding it, post-traumatic stress.” [another participant] said something very similar when she was talking about reading Alice Miller. For her it also took the fear away. (07.08.2015)

(4) Interesting how we solved her discomfort of feeling she has to perform. I felt that it got better afterwards. She appeared less stressed (less ‘I don’t know’s; a little more elaboration and examples) (26.08.2015)

(5) change in atmosphere and speech: longer pauses, quieter speech, sounds more thoughtful, sensitive and careful too; indicating that this is a different topic and different matter to the stories before (02.10.2015)

Figure 2. Examples of notes taken in research diary during transcription
3.15.4. Initial coding

The second step of the analysis involved line-by-line coding. This initial coding phase is a process that breaks down data into small units and labels these units (Charmaz, 2014; Sbaraini et al., 2011). Charmaz (2014) recommended to code line by line, to use gerunds in labels to emphasise action and process, to stay close to the data but open to all directions, to code early, quickly, spontaneous, and to keep codes short and simple. While line-by-line coding ensures that the researcher stays close to the data and keeps emerging codes ‘grounded’ (Charmaz, 2014), line-by-line coding appears somewhat arbitrary (Chenail, 2012b; Rich, 2012). This is because a line is determined by the choice of font and font size, justifications, and the document margins, shape or size. Chenail (2012b) cautioned that this could lead researchers to misidentify meaningful units of data, capturing too much or not sufficient meaning in one line. Instead, he recommended that “it is fine to read a transcript line-by-line to help slow down your pace of assessing suitable elements” but that analysis should differentiate meaning and not lines (Chenail, 2012b, p. 266). Therefore, in this study, transcripts were read line-by-line, but coded in small meaningful units. For one participant, for example, lines of the same section were coded in the following way (Figure 3):

Transcript:
“This is when I get really confused between the trauma stuff and the addiction stuff because early in recovery my self-esteem was on the floor. I was < a few > months clean when I went to the < specialist treatment centre >. I still wasnae in a place where I fell ... worthy. With being clean I didn’t feel worthy getting help. ...

Code label: Confusing trauma and addiction

Transcript:
“This is when I get really confused between the trauma stuff and the addiction stuff because early in recovery my self-esteem was on the floor. I was < a few >
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months clean when I went to the <specialist treatment centre>. I still wasnae in a ¶ place where I fell ... worthy. With being clean I didn’t feel worthy getting help. …”

**Code label:** Lacking self-esteem early in recovery

Transcript:

“This is when I get really confused between the trauma stuff and the ¶ addiction stuff because early in recovery my self-esteem was on the floor. I was < a few > ¶ months clean when I went to the <specialist treatment centre>. I still wasnae in a ¶ place where I fell ... worthy. With being clean I didn’t feel worthy getting help. …”

**Code label:** Feeling unworthy getting help

Figure 3. Example of four lines of one transcript with codes allocated to meaningful units (¶ shows line break in the transcript original; grey highlighting shows unit to which code has been allocated)

What this example also shows is that text segments, in the majority of cases, were coded using gerunds (e.g., confusing, lacking, feeling). This was mostly straightforward, but occasionally unsuitable, for example, when wanting to capture in *vivo* expressions (such as “Don’t be nice to me because I’m not used to it.”), relevant non-action (such as stating the fact of having children while in an abusive relationship), or effects of external circumstances on the trauma survivors (such as social services taking a trauma survivor’s child into care). Such challenges were also highlighted by Rich (2012). The current study coded these incidents, nonetheless, where they seemed relevant to participants’ trauma and recovery experience.

Frequently, in these cases, gerunds of inaction were used, such as ‘being’ or ‘having’ (e.g., “having two children while in abusive long-term marriage”, “having taken away one’s child”, “no more being at begging call of abusive mum”); occasionally they included alternative labelling (e.g., “unable to help myself then”, “unaware of avoiding decision-making”).

While the labels should stay as close to participants’ wording as possible (Charmaz, 2014; Rich, 2012), where they differ this begins a process of interpretation (Chenail,
Similarly, choosing what to code – whether coding or not coding text, or coding or not coding different meanings within one segment – interprets the data and constructs new information. In the initial coding stage of this study, codes were given labels that resembled participants’ wording in most cases. However, some rephrasing was inevitable in order to, for example, keep codes simple and short, or comply with using gerunds. The above Figure 3 illustrates the close match of the transcript segment “early in recovery my self-esteem was on the floor” with the code “lacking self-esteem early in recovery”. Nonetheless, ‘lacking’ is an interpretation of “my self-esteem is on the floor”. The researcher has constructed meaning, albeit small. By contrast, the segment “I was < a few > months clean when I went to the < specialist treatment centre >. I still wasnae in a place where I fell … worthy. With being clean I didn’t feel worthy getting help.” was coded less closely as “feeling unworthy getting help”. The researcher inferred that the repetitions boil down to the core meaning of feeling unworthy to ask for help, and the information of being a few months clean before seeking specialist treatment was included to provide context to the core meaning. Similar considerations were undertaken throughout the initial coding phase.

The researcher aimed to keep codes short and simple and to code quickly. However, this was not as straightforward as advised by Charmaz (2014). Frequently, a decision had to be made whether to code a shorter unit of text (e.g., “knowing that it is not acceptable” and “knowing that you’re okay”) and then risk fragmenting it, pulling it out of context to such an extent that it became unrecognisable and meaningless; or to code a larger unit of text with a longer code to preserve the context and multiple meanings (see Table 6). This decision could not be made spontaneously and quickly but required some reflection.
### Table 6

<table>
<thead>
<tr>
<th>Transcript segment</th>
<th>Assigned code</th>
<th>Alternative coding</th>
</tr>
</thead>
<tbody>
<tr>
<td>“half of the ... battle is knowing that it is not acceptable, and you’re gonna be okay”</td>
<td>believing that half the battle is knowing abuse is not acceptable, and you’re gonna be okay</td>
<td>knowing that it is not acceptable, and you’re gonna be okay</td>
</tr>
</tbody>
</table>

**Simultaneous initial coding and memo-writing**

During the initial coding phase, the researcher recorded insights, observations and patterns from each interview transcript, and changes in coding strategies in the research diary. This assisted in identifying what was going on in the data, what talk was omitted, and similarities and differences between interviews. Questioning these instances enabled further reflection. Compared to the brief transcription notes, coding notes were in paragraph form where ideas were articulated more elaborately and reflected upon. As a result, patterns in the data became gradually visible.

**Simultaneous initial coding and constant comparison**

It also made constant comparison possible. Instances across interviews were compared. Additionally, text was compared with text, and text with codes to decide whether a text segment could be allocated to an existing code or required its own label. In memos, the researcher questioned whether labels (such as “knowing ...” and “understanding ...”) had similar or different meanings. Once the researcher began to have a better grasp of the data, constant comparison prompted rephrasing of code labels. For example, some labels appeared too specific (e.g., “looking for help and support for over 30 years”, “starting to open up with counsellor”) and became more general (e.g., “looking for help and support for many years”, “starting to open up with counsellor or in group”) to avoid unnecessary repetition. While it
felt overwhelming at times to question the data constantly, and to consider all data as potentially relevant, constant comparison and simultaneous memo-writing ensured the fit of text and code.

3.15.5. Focused coding

The third step of the analysis required going through the initial codes, and then raising codes with significant meaning to focused codes, grouping together those codes that shared similarities, or discarding initial, but fruitless, codes (Charmaz, 2014; Willig, 2013). In either case, this process prepared the researcher to move away gradually from the descriptive level of the initial coding toward an increasingly more analytic level. Focused coding in this study began after initial coding of transcripts one to eight. Charmaz (2014) suggested looking for codes that are *telling* something and that spark insight and excitement. She also suggested continuing coding quickly and keeping it simple. In this study, insightful early focused codes comprised:

- “addiction-related only”. This captured talk around addictions and recovery of addiction only, without referring to trauma. The researcher aimed to remove this as (temporary) excess from the remaining initial codes to help focus the analysis on trauma aspects. However, there was also an awareness from reading through transcripts, from reading previous literature and from working previously in an addiction-and-trauma-recovery environment that addiction may play a part in trauma recovery. Therefore, it was not discarded, but parked on the side for later consideration.

- “connection between addiction and trauma recovery”. This focused code attempted to investigate the potential link between addiction and trauma, and the relevance of “addiction-related only” aspects.
“internal processing of trauma”. This captured initial codes referring to “assuming …”, “believing …”, “reflecting on …”, “realising…”, being “unaware of …” or “being/becoming aware of …” something related to trauma and recovery. Sub-categories quickly formed within this focused code (e.g., “blaming in interpersonal context”, “identifying with others”, “negative feelings”, “seeing things differently”). At a later stage, these became focused codes or categories in their own right, and “internal processing of trauma” became less important because its label and concept did not originate from participants’ talk.

“contact with professionals and services”. This captured talk on seeking and engaging with professionals and services.

“defining recovery”. This captured participants’ view of what trauma recovery means to them and any alternative expressions. Understanding the overall goal of survivors, if any, was also felt to help answer the research question.

“toolbox”. This focused code collected initial codes of practices or behaviours (such as meditation, writing, talking to friends) that did not require engagement with professionals and did not refer to internal processing.

“feeling good”. This captured talk on positive emotions and emerged as focused code because the researcher felt surprised to find positive experiences. It challenged the notion of survivors feeling unhappy all the time.

These topics formed early focused codes – here also called categories – to which initial codes were allocated.

Table 7 shows an example of text segments with corresponding initial codes assigned to the category “disowning or distancing from abuser to find safety and breathing space”.
### Table 7

**Example of text segments and corresponding initial codes assigned to the category**

<table>
<thead>
<tr>
<th>Text segments</th>
<th>Initial codes</th>
<th>Focused code</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Yeah, that was just a couple of year ago. And so I didnae have anything to do with her for a couple of year. Cut out of my life and it’s the best I felt in years.” (participant 02)</td>
<td>The best I felt in years. [in vivo] (cutting mum out of life)</td>
<td>Disowning or distancing from abuser to find safety and breathing space</td>
</tr>
<tr>
<td>“They were two, two (very odd) characters, my &lt;parents&gt;. You know. End of! You are not. And you are out of it. And that was a long time ago.” (participant 04)</td>
<td>separating herself from past and from &lt;parents&gt;</td>
<td></td>
</tr>
<tr>
<td>“that my stepfather ... – I just hate; I don’t even know what to call him because I’m that ripped apart by him.” (participant 09)</td>
<td>not wanting to call him stepfather</td>
<td></td>
</tr>
<tr>
<td>“And it’s very (daunting), the decisions that I’ve made. Like, when I moved here I decided I can live here because – no matter what – nothing can be as bad. So, anything is better than staying. So I went.” (participant 11)</td>
<td>Anything is better than staying.</td>
<td></td>
</tr>
<tr>
<td>“But now, I walk past but I keep walking. I mean, I wouldn’t, you know, maybe, if some men might say ‘good afternoon’ or whatever. I just keep going. You know, I can’t. I wouldn(n’t) isolate ; I wouldn’t put myself in a situation where I was standing in the street myself with them, or, you know, going into a lift, or going into a whatever, a situation.” (participant 12)</td>
<td>helping myself by avoiding places with men</td>
<td></td>
</tr>
</tbody>
</table>

In addition, a category was created and labelled “set aside for now”. It collected all excess codes without deleting them and, thus, allowed to revisit them at a later
stage. As Charmaz (2014) indicated, allocating initial codes to categories was straightforward in most cases. Occasionally, the researcher assigned initial codes to several categories because the content of these codes reflected different aspects. However, it was not always clear to which category to allocate codes. For instance, the initial code “being excluded from family when confronting abuser” was allocated to the category “negative interpersonal contact” (which collected negative experiences involving other people). Then, in a diary entry, the researcher questioned assumptions of regarding this experience as negative and considered that it may have been experienced as positive too (Figure 4). This illustrated that focused coding was not always straightforward and quick, but required reflection.

19.11.2015. Why do I assign “being excluded from family when confronting abuser” into “negative interpersonal contact”??? I seem to assume that being excluded from your family is a bad thing. But is it for this person? I got the impression that she did feel let down but at the same time it wasn’t very surprising at the time [for her] and she doesn’t feel bothered by it much today. But she isn’t pleased about this either. So I’m going to leave this code in this category.

Figure 4. Example of diary entry (memo) showing a reflection of assumptions which informed (re)allocation of initial code

Simultaneous focused coding and memo-writing

The researcher continuously questioned data, codes and categories to ensure best fit when assigning coded text to categories. Again, writing insights, questions and reflections in the research diary provided the space to interrogate data, codes and categories explicitly (as shown in Figure 4). In particular when questioning similarities and differences among initial codes (e.g., Is ‘hating’ someone different or similar enough to feeling anger toward someone?), among focused codes (e.g., Is “distracting oneself” from trauma material the same as “denying or avoiding trauma processing”?), and between initial and focused codes (e.g., Does the text and code “It’s all me.” match with the category “blaming oneself”, with the category “blaming
others”, or with both?), memos made interpretative nuances visible. The researcher, then, reflected on these nuances and justified her decision in writing. This left a research trail. Memos also contained early property descriptions of categories.

**Simultaneous focused-coding and constant comparison**
Throughout the analysis process, constant comparison, questioning and reflecting prompted the researcher to create new focused codes, to relabel focused codes, to create sub-categories in focused codes, to move sub-categories out of focused codes and make them focused codes in their own right, and to move focused codes into another focused code and turn them into sub-categories. Because of constantly adapting focused codes, the researcher also checked the fit of initial codes allocated to these focused codes. Subsequently, initial codes were reallocated to ensure that the descriptive data (i.e., source text and initial codes) fitted the analytic components (i.e., sub-categories and categories / focused codes). Thus, analytical interpretation remained grounded in the data. For example, initial codes of different feeling-experiences, such as anger, sadness, or frustration, began to accumulate in the category “feelings”. The researcher decided to differentiate this ‘feeling’ category by creating sub-categories of, for example, “feeling anger”, “feeling shame” and “feeling frustrated when trying to communicate experiences”. This required moving initial codes that referred to these specific feeling-experiences from the overall “feeling” category to its constructed sub-categories.

**Continuous development and refinement of categories**
The researcher documented the development and refinement of categories and sub-categories over time in a spreadsheet (see appendix L). To illustrate this here briefly, the initial categories created within the first month of focused coding comprised “addiction-related only”, “beliefs and identity”, “connection between addiction and trauma recovery”, “contact with professionals and services”, “defining recovery”, “flashback experiences”, “feelings”, “internal processing of trauma”, “negative interpersonal contact”, “help from friends and family”, and “set aside for now”.

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Focused coding of eight interviews – predominantly from the community site – was followed by a thorough crosschecking of initial codes, categories, and code-to-category allocation. This ensured that categories are grounded and robust before beginning to categorise codes from the next round of interviews – predominantly from the clinical site. The number of categories at this point had grown considerably, and many categories had been refined. The discussion, here, will zoom in on only a few categories and sub-categories. For example, the previous category “addiction-related only” was relabeled to reflect action (using gerunds); and sub-categories were created to reflect nuances. These changes also suggest the researcher’s shift in interpreting the role of addiction in trauma recovery. Addiction and addiction recovery appeared to play a meaningful role in the recovery from trauma, and sub-categories crystallised an addiction-trauma process. Also, the previous category “beliefs and identity” underwent changes. ‘Identity’ was separated from ‘belief’ and relabeled as action “becoming who I was and who I am”. In addition, its sub-categories were refined. By contrast, the sub-category “blaming in interpersonal context” (previously located in “internal processing of trauma”) accumulated a considerable amount of initial codes and, therefore, demanded to become a category in its own right. Additionally, the researcher split it up into “blaming others” and “blaming oneself” to reflect distinct differences. Sifting through and clustering initial codes led to the creation of new categories. For instance, “bad experiences with intimate adult relationships” was added to cluster accumulating talk on this subject; “being affected still today” was added which identified that trauma recovery was incomplete and ongoing; and “being there for me” was created because it allowed the researcher to explore what participants meant when articulating that someone was there for them.

When the process of focused coding was completed, categories and code-allocation had been modified again. However, there were less additional categories and, instead, more refinement within them, including negative and odd cases. For
example, participants talked about “finding words for describing trauma and recovery journey”. The researcher subdivided this category and, thereby, identified different properties. These indicated that survivors were “being explained” by others about trauma and recovery and these others were “calling trauma [and] abuse for what it is”; survivors found it “difficult to explain” their trauma and related difficulties to others; they were “using analogies to communicate” their inner experience; and some were “using trauma-specific terms”. As a result, categories and sub-categories became more established and nuanced when coding transcripts 9-15. The final category structure can be viewed in appendix M.

3.15.6. Theoretical sampling and saturation

Part of focused coding and, the next step, theoretical coding is theoretical sampling and reaching saturation. Theoretical sampling implies collecting more data in order to extend and refine the categories and their properties (Charmaz, 2014; Sbaraini et al., 2011; Willig, 2013). It does not mean, as Charmaz (2014) emphasises, a kind of sampling intended to answer the research question, sampling that reflects population distribution, sampling to identify opposite cases, or sampling until no new information can be found. For theoretical sampling to be meaningful, some provisional theoretical concepts must have been constructed from the data (Charmaz, 2014), and the researcher should have identified some questions and gaps that he or she can follow up in the field. Simultaneously, theoretical sampling aims to achieve saturation. Saturation implies that additional data collection would not reveal further attributes or new insights that could refine the theory (Charmaz, 2014; Sbaraini et al., 2011; Willig, 2013). However, saturation should be viewed as an ideal rather than an achievable goal. Ryan and Bernard (2003) and Willig (2013) advised that additional data may always produce further insight, alterations to codes and categories, or changing perspectives with regards to the theory. Therefore, Ryan and Bernard (2003, no pagination) suggested to stop sampling when “we are willing to
miss rarely-mentioned” cases, and when a certain number of interview participants “in a row (say five or more) fail to mention any new” information.

As demonstrated in the previous section, focused coding in itself allowed the researcher to refine categories and establish their properties. Also, additional interviews have been collected alongside initial, focused and theoretical coding. Yet, theoretical sampling requires not only to conduct further interviews but also to use focused questions in interviews to help clarify gaps of categories and their properties. The present study followed this requirement to a certain extent. Firstly, after interview one to three, the researcher identified initial topics and questions from reading in-depth through the transcripts. These were followed up in the next interview round to further the analysis. Secondly, when focused codes developed, for example around different “feelings”, the researcher identified gaps around feeling angry and feeling shame. Additionally, survivors talked of others “being there” for them and it was unclear what this expression meant to them. Again, the researcher took these questions to subsequent interviews to develop the analysis. Afterwards, uncertainties remained about interpersonal aspects, such as quality contact, trust, and avoidance of intimacy. Again, properties of categories relating to these topics were explored in subsequent interviews.

While the researcher conducted the final three to four interviews, fewer questions were followed up that would refine category properties. On the one hand, this may have been due to reaching saturation and, indeed, only few new insights emerged and few refinements developed after having analysed these interviews. On the other hand, the researcher reflected that grappling with the data was difficult and messy and, consequently, it was challenging to determine further interview questions that might improve the key concepts. That is, the ongoing focused and theoretical coding in itself, prior and alongside the final data gathering stage, caused categories and their properties to change and be refined continuously. Therefore, the researcher’s understanding of the key concepts continued to change. Questions about the data felt vague.
and unfocused because they were themselves subject to change from ongoing coding. The researcher acknowledges that theoretical sampling in the final analysis stages was not pursued as systematically as advised by Charmaz (2014). In hindsight, a solution may have been to schedule the final few interviews at a later time to allow the researcher to complete coding and categorising of all data gathered at that point first. Alternatively, another round of interviews could have been conducted after interview 15. However, this would have jeopardised the timely completion of this study.

On another note, it is not uncommon to have unresolved concepts in grounded theory. After all, scientific theories are tentative. For example, Lois followed up a theoretical category six years after the initial study of ‘temporal emotional work of motherhood’ had ended (cited in Charmaz, 2014). Despite the shortcoming in the present study, the interview data gathered were rich and, therefore, revealed key concepts with multiple properties and nuances. This allowed developing a comprehensive understanding, nonetheless. Thus, the researcher continued theoretical coding and theory building.

### 3.15.7. Theoretical coding and theory development

In the final step, the researcher coded data theoretically and developed a substantive theory. According to Charmaz (2014, p. 344), a substantive theory is a “theoretical interpretation or explanation of a delimited problem in a particular area”. Grounded theories – as other scientific theories – are considered open for debate, context dependent, incomplete and provisional (Charmaz, 2014; Rich, 2012; Sbaraini et al., 2011). Theoretical coding is the method to arrive at this theoretical explanation. It involves linking categories anew in such a way that they “tell an analytic story that has coherence” (Charmaz, 2014, p. 150). In the current study, this entailed constructing a coherent story of how adults recover after exposure to interpersonal violence and subsequent trauma based on the categories and sub-categories that
were supported by the data. To distinguish clearly between focused and theoretical coding, focused coding fractures data and reorganises the pieces, while theoretical coding “weaves the fractured story back together again [into] an organised whole theory” (Glaser, 1978, p. 165; also supported by Charmaz (2014)). While Glaser (1978, 2005) attempted to apply a framework to doing theoretical coding, such as the six Cs (i.e., looking for causes, context, contingencies, consequences, covariances and conditions), Charmaz (2014) cautioned that this might force the data into a coherent story instead of letting the data speak for themselves. Therefore, in the present study the researcher did not apply a framework and, instead, recorded the thought processes, decisions and progress in memos. Diagrams and mind maps also became important tools to visualise relationships (Charmaz, 2014; Rich, 2012).

The researcher began to examine connections when early substantial categories formed during focused coding. A mind map showing all substantial categories and sub-categories at the time served as a valuable tool. Then, the researcher scanned the visual representation of the data for topics that appeared similar, connected, or told a story of trauma recovery. Lines, circles and notes were added to record insights, relationships and process. An example can be found in appendix N. The researcher constantly compared categories and sub-categories, and questioned in what way they might relate. Emerging theoretical categories that might explain trauma recovery as well as emotional and relational aspects included: “making sense of things”, “learning, [mental] shifts, and seeing things differently”, “substituting family with new attachment figures”, and a “changing identity”. This unfolded as a potential story. The researcher began to speculate that perhaps a desire to make sense of one’s trauma history and current difficulties may prompt survivors find out and learn what is going on. One way of doing so may be to seek professionals or allow peer survivors and friends to help. By being exposed to these interpersonal experiences, survivors also expose themselves to new situations and information where they gain insights into trauma, their current difficulties and recovery. As a result of this new information, they might begin to see themselves differently.
However, from this story several questions remained unanswered. For example, the researcher questioned: Was it really a desire of wanting to make sense? And if so, what caused this motivation? What exactly was it that they wished to make sense of? How did they allow peer survivors, friends and professionals to help them? Were there any barriers to this? Were there other non-interpersonal ways to make sense? What was it about peer survivors, professionals and friends that was supporting adults’ recovery? What kind of understanding and knowledge did survivors gain from different sources? These questions prompted the researcher to interrogate the data further through continuous focused and theoretical coding.

Although focused coding resulted in a hierarchical system of categories, sub-categories and codes, it was visible from this example that the researcher regarded items as fluid and less fixed when coding theoretically. That is, the researcher observed that some items were similar albeit being assigned to different categories. For instance, “feeling shame and guilt” (sub-category) in the category “feelings”, “being made an inadequate person by others” (sub-category) in the category “becoming who I was and who I am”, and the category “blaming oneself” appeared connected in that they suggested survivors’ feelings of shame, and their tendency to blame themselves may be the result of having been abused or neglected (Figure 5).

![Figure 5. Example of hierarchical coding structure and of sub-categories of different categories relating to one another](image-url)
When categories became increasingly refined during focused coding, the researcher checked whether the earlier concepts held true or changed. Evans (2013) suggested that, in grounded theory, it can be challenging to switch between breaking down data in details (required of initial and focused coding), and abstract thinking (required of theoretical coding). This was also experienced in this study. In order to gain distance from the close interaction with the fragmented data and to allow more abstract thinking, the researcher printed the labels of all categories and subcategories on paper, cut each out and then moved these about more freely. The goal was to form a few key concepts which most categories and sub-categories clustered around, and to lay those categories and sub-categories that fit in or between two concepts in the middle. The latter strategy would suggest processes or relationships between two concepts. A digitalized version of this mind map from paper snippets can be viewed in appendix O. Four core concepts emerged from this exercise:

1) Survivors reshaped or reconstructed their self to become a stronger valuable ‘me’
2) survivors acquired and used language and communication strategies to make sense of their past and present experiences
3) survivors were like scientists who questioned, researched, compared or contrasted and tested out information, behaviours, situations to change their life
4) survivors accepted support from others and formed social bonds.

**Simultaneous theoretical coding and memo-writing**

Through memo-writing, the researcher defined and interrogated these concepts further, and identified and labeled the processes between these core concepts in memos. This interaction with theoretical codes resulted in a few further alterations before arriving at the current final theory presented in the results chapter. A substantial memo entry showing these developments can be found in appendix P.
Simultaneous theoretical coding and constant comparison

At last, the final concepts were cross-checked with the allocated focused codes, initial codes and text segments to ensure that theoretical codes fitted and were grounded in the data. An example is shown in Table 8.

Table 8
Example of matching text segments, initial codes, focused codes and theoretical codes

<table>
<thead>
<tr>
<th>Text segments</th>
<th>Initial coding</th>
<th>Focused coding</th>
<th>Theoretical coding</th>
</tr>
</thead>
<tbody>
<tr>
<td>“You know what? We’re going to fucking name and shame it.’ ((laughs)) You know. We’re gonna find names for it when it happens. So you realise it’s separate from you but you’re feeling it. But it’s not you.”</td>
<td>separating</td>
<td>experiencing</td>
<td>making invisible</td>
</tr>
<tr>
<td>(participant 4)</td>
<td>flashback-feelings</td>
<td>flashbacks (subcategory: finding words for it)</td>
<td>experiences visible</td>
</tr>
<tr>
<td>“Because I could see it. It was, like, visual. That stuff like ‘I’m worth it today.’ Do you know. ‘I can do this.’” (participant 5)</td>
<td>making positive thoughts visual in written affirmations</td>
<td>tool box (subcategory: using affirmations)</td>
<td></td>
</tr>
<tr>
<td>“To explain that it wasn’t acceptable to put up with that sort of (?). You know, the physical and sexual abuse. It wasn’t normal.” and “So (for going about) all that time, then to all of the sudden been told ‘That’s not acceptable. That”</td>
<td>being explained by professionals</td>
<td>finding words for describing trauma and recovery</td>
<td></td>
</tr>
<tr>
<td></td>
<td>that abuse isn’t normal or</td>
<td>journey (subcategory: being explained)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>acceptable</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
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</tbody>
</table>

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<table>
<thead>
<tr>
<th>Text segments</th>
<th>Initial coding</th>
<th>Focused coding</th>
<th>Theoretical coding</th>
</tr>
</thead>
<tbody>
<tr>
<td>isn’t how it should have been.”</td>
<td></td>
<td></td>
<td>reconstructing</td>
</tr>
<tr>
<td>(participant 12)</td>
<td></td>
<td></td>
<td>reality</td>
</tr>
<tr>
<td>“But then, I think I probably just read some more about, just, how to start dealing with trauma. And learn about trauma.” (participant 2)</td>
<td>reading more</td>
<td>not having known before what</td>
<td>reconstructing reality</td>
</tr>
<tr>
<td></td>
<td>about trauma to deal with it and learn about it</td>
<td>trauma and being traumatised is (subcategory: about trauma responses and symptoms); tool box</td>
<td></td>
</tr>
<tr>
<td>“cause I didn’t see it as rape”</td>
<td>I didn’t see it as rape.</td>
<td>not having known before what trauma and being traumatised is (subcategory: about abuse and traumatic event)</td>
<td></td>
</tr>
<tr>
<td>(participant 8)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>“At the end of the course, you know, I can’t ... deny it any more, if you like. I can’t, sort of, say ‘It didn’t really happen to me. It wasn’t that bad.’ It really was. It’s the first time it’s ; I come to terms with the fact that it was. Which I think is, you know, helped a lot as well.” (participant 14)</td>
<td>understanding from course more ‘the way I live my life and WHY I live that way’ (anxiety, depression)</td>
<td>seeing trauma experiences, people, myself, the world etc differently now; becoming who I was and who I am (subcategory: becoming a new person)</td>
<td></td>
</tr>
</tbody>
</table>

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3.16. **Summary**

Overall, this study underwent thoughtful prior considerations about how to conduct this piece of research. Ontological and epistemological positions were considered and the researcher decided to take a relativist and constructivist view. A qualitative method was presented as a suitable way to answer the research question of how adults recover after exposure to interpersonal violence and subsequent trauma, any key components and processes underlying this recovery and, in particular, emotional and interpersonal functioning of these processes. Among different qualitative methods, constructivist grounded theory allows to study processes, such as the one in question here, as well as to arrive at a substantive theory. This chapter outlined and justified strategies for sampling, study material, safeguarding procedures, data management, recruitment, interviewing, quality criteria, reflexivity, and data analysis applied in this study. These methods arrived at a substantive theory that will be presented in the next chapter.
Chapter 4: Study results and a theory of trauma recovery

4.1. Introduction

This study asked how adults recover from experiences of interpersonal trauma and what ingredients facilitate this process. It considered, in particular, how trauma survivors manage emotions and interpersonal aspects in day-to-day life, and explored how they might gain emotional and interpersonal skills following abuse and trauma. The key elements and processes that can be derived from this study will help develop a theory of emotional and interpersonal skills development in trauma recovery.

This chapter presents the results in two parts. To begin with, it will describe the demographic characteristics of the interview participants. Then, the first part will present an overview of the generated thematic categories. These categories represent the key components of trauma recovery, illustrated in Figure 6. Subsequent sections will describe each of them in turn, illustrate them with examples from the data, and interpret these findings with reference to academic literature. The second part will weave these key components of trauma recovery together into a narrative, and flesh out the interactions between components as well as key processes of the recovery journey. The synthesis presents a theory of the social reconstruction of trauma in recovery with a focus on emotional and interpersonal functioning. Because this study explores the recovery journey from the individual’s point of view, the theory concentrates on the micro level. That is, it focuses on the individual and a few key support contacts (such as peer survivors, health professionals, and a friend or two). However, the data suggested that key
components and processes may also translate to a wider social and cultural scale, and this finding will be discussed towards the end.

4.2. Description of participants

The first section describes the sample for this study. Such a description is useful because it can indicate to what type of people and experiences the findings of this study may apply outside the given sample. It may also reveal additional issues related to or impacting on trauma recovery that could supplement the current findings or future investigations. Most data in this description originate from the demographic questionnaire that participants completed.

The sample consisted of fifteen women. They were interviewed face-to-face in 2015/2016. Seven participants attended the community research site and eight participants attended the clinical research site. Three out of fifteen participants happened to attend both. This only came to light during the interview. Their age ranged from early 20s to their 60s. Almost all of them disclosed some form of abuse or neglect in childhood (with seven reporting childhood sexual abuse), while three of them focused their stories on experiences of intimate partner violence in adulthood. All women reported having attained qualifications of further or higher education. However, ten were not in work and four were in part-time work at the time of the study, leaving only one participant in full-time employment. With regards to parenting, eleven women reported having children and eight of them were living with their children. Twelve women were single and three were in a relationship. In addition, three participants disclosed during the interview that they identified as LGBT. This also included an individual who had undergone sex change.
4.3. **Key components of trauma recovery**

The analysed data from these individuals generated four key components: (1) disengaging from feelings, social situations and oneself, (2) making invisible experiences visible, (3) examining one’s life in relation to abuse and trauma and (4) reconstructing reality. Four additional subcomponents have been grouped together under ‘reconstructing reality’. They comprised (a) reframing of abuse and subsequent trauma, (b) reconstructing choice and control, (c) reconstructing beliefs about oneself, and (d) shifting and sharing of responsibility for abuse and recovery. Figure 6 shows these key components in a visual diagram. The following four sections will describe each component in turn and highlight their relevance to overall trauma recovery as well as to emotional and interpersonal functioning. Extracts from this study’s interviews will illustrate the main points. Each section will also draw on existing literature to examine the extent to which these findings resemble or differ from what is already known.

*Figure 6. Four key components of trauma recovery, with subcomponents*
4.3.1. Disengaging from feelings, social situations and the self

One major coping strategy reported by trauma survivors in this study was disengaging or getting away from suffering. This came in various forms, such as passively avoiding experiences, suppressing one’s thoughts, distracting oneself with different activities, or distancing and escaping from an abusive environment. The term ‘disengagement’ from Naragon-Gainey et al.’s (2017) meta-analysis was used for this study because it reflects the nuances of avoidance-like strategies that I observed in this group of trauma survivors. Their review concluded that this term summarises a group of specific emotion regulation strategies found in multiple studies, namely attentional and behavioural avoidance, and distraction – with strong factor loadings – and experiential avoidance, expressive suppression, and mindfulness – with weaker factor loadings. Other responses, proposed by Krypotos et al. (2015), were passive avoidance and active avoidance (‘escape’) for which neurological differences have been reported confirming variations in avoidant coping strategies. In particularly, the strategies of avoidance and suppression have been recognised as key difficulties and maladaptive ways of coping in the trauma literature (e.g., Krypotos et al., 2015; Schubert, Schmidt, & Rosner, 2016; Shechner & Bar-Haim, 2016; Turliuc, Măirean, & Turliuc, 2015), and has been included in the PTSD diagnosis (e.g., American Psychiatric Association, 2007). Therefore, it was not surprising that disengagement strategies emerged as an important component in this study.

In this study, disengagement strategies seemed to be participants’ predominant form of coping before they sought help or when no supportive others were available. Three key aspects were identified. Firstly, participants tended to disengage from emotional pain. They did so by numbing, ignoring or dissociating from uncomfortable feelings, such as anxiety, panic, sadness, frustration, abandonment, anger, resentfulness, shame, or confusion. In this respect, alcohol, drug and medication misuse as well as self-harm and staring into space were reported.
strategies to dampen down distress. For instance, participant 03 reported “things would get too much and then I hit the drink. … I’m not surprised I drunk, the way that I did. Ken. The feelings that I had and whatever else… Cause I just had no, I had no control over my own life. I had no say in my own life.” Particularly, participants from the community site reported using substances to numb emotional pain, which is not surprising considering that the site also offered support for addiction recovery. Survivors also distracted themselves from emotional pain with activities, such as exercising, taking pictures, knitting and meditating. The feelings they aimed to escape from originated, for example, from intense flashbacks of trauma memories (e.g., “I don’t know if the army [in my head] are there – the anxiety rises – and I don’t know if the army are there to protect me or fight against me. So there is this confusion going on in my body.” Participant 04), from having been hurt by people before and anticipating this to happen again (e.g., “I think the biggest part of it is cause I’m scared of being hurt again, in case she isn’t trustworthy.” Participant 09), and from not understanding why life was giving them a bad deal (e.g., “How can somebody have such bad luck? You know. (?) But … cause I always felt: how can; how can things like that happen to you? One thing after another, after another, after another.” Participant 13).

Secondly, trauma survivors reported disengaging from people. They did so by isolating themselves at home (e.g., participant 09), moving away from an abusive family (e.g., participant 11), reducing or breaking up contact with the abuser or those who did not protect the abused (e.g., participant 02, 04, 07, 10, 12, and 14), by distrusting others, and by staying away from intimate relationships, from men or from women, or locations where people can be found (e.g., buses, changing rooms). This strategy was common for participants from the community site as well as from the clinical site.

Thirdly, participants avoided looking at their traumatic experience, past and present, how they are affected by it now, and how they might have contributed to it. For example, participant 06 reported “I often deal with it [what happened] or run away
Chapter 4: Study results and a theory of trauma recovery

from it. I lock it behind the door and then go away and not deal with that.”. Similarly, participant 14 stated “It’s like I feel like I’m constantly kidding myself? Like, I have done my entire life. ‘There’s nothing wrong with me. I’m absolutely fine. I can do this.’” They appeared to disengage from what happened to them and the affected part of themselves. Again, substance abuse was a chosen strategy to ‘solve’ traumatic experiences. However, data also suggested that helping others, often saying ‘yes’ to other people’s requests, and pretending that everything is fine when it is not served to enable some participants to deny their problems.

In the trauma literature, it has been unclear what exactly trauma survivors disengage from. Some authors have limited their concept of avoidant coping to disengaging from fear, negative emotions, or danger (e.g., Krypotos et al., 2015; Nawijn et al., 2015; Shechner & Bar-Haim, 2016). Other authors generalised it to ‘trauma-related’ material (e.g., Seligowski et al., 2015). Yet, these reports have not explained whether it is the fear itself or the stimuli that induced this fear from which survivors try to disengage. Previous research has also not considered what survivors perceive as negative emotion, as dangerous, or as trauma-related. Findings in this study suggested specific emotions – not limited to fear – were avoided, as well as emotional discomfort more generally where survivors were unable to identify feelings and their source. This study also suggested that survivors avoided abusive others, people generally, objects reminding them of the perpetrator and the abuse (e.g., the table that participant 01 had sat at, or a coin participant 02 had received from the perpetrator at the time of the abuse), and even their own thoughts and emotions in order to prevent further harm.

Furthermore, the trauma literature has focused predominantly on avoidance and suppression (Garland, Farb, Goldin, & Fredrickson, 2015; Krypotos et al., 2015; Nawijn et al., 2015; Schubert et al., 2016; Seligowski et al., 2015; Shechner & Bar-Haim, 2016; Turliu et al., 2015) while little has been reported about the role of distraction and escape (Naragon-Gainey et al., 2017). The findings of the present
study showed that escaping or distancing from the perpetrator and a toxic environment was important. Survivors reported making a difficult decision when leaving: “And it’s very (daunting), the decisions that I’ve made. Like, when I moved here I decided I can live here because – no matter what – nothing can be as bad. So, anything is better than staying. So I went.” (Participant 11). A study by Oaksford and Frude (2003) found that avoiding the abuser was a common immediate and a long-term coping strategy. Similarly, survivors in the present study distracted themselves. That is, they did not only turn their attention away from distress – which resembles avoidant coping – but they also turned it towards other activities, such as taking pictures or exercising, with reported positive benefits. More research may be needed to disentangle distraction from avoidance.

Strikingly, escaping from negative feelings, people and oneself was mostly a self-imposed activity: For instance, survivors did not report that they were encouraged by others to self-harm or to stay away from people because it would address their feelings of distress or keep them safe. Although alcohol and drug consumption was occasionally a social activity, drinking/drug companions were not perceived as supporting the trauma survivor to solve their emotional problems. Survivors also decided on their own to distance themselves from abusive others. Some survivors reported that they perceived it as unsupportive when they were discouraged to talk about their trauma experience, and as supportive when others helped them manage their feelings or look at themselves. Similarly, when professionals, peer survivors or friends were seen as supportive, ‘disengagement’ strategies appeared to diminish and, instead, survivors began to address their negative feelings, seek out others, and look at themselves.

This reduction in ‘disengagement’ indicated that choosing to disengage from feelings, people and self may have had a useful function in a context where alternative resources and support were unavailable. This challenges previous studies that have viewed disengagement strategies largely as maladaptive,
reporting evidence that these strategies lead to further distress, and can manifest in disorders such as PTSD (Krypotos et al., 2015; Shechner & Bar-Haim, 2016; Turliuca et al., 2015). This was also largely the case in my study – namely that disengagement strategies used long-term and as main source of coping increased distress. However, it was important to note that participants also reported that avoidance, suppression, distraction or escape provided a helpful breathing space and a break from ongoing stressful situations in their lives where such respite was unavailable from other sources (such as supportive others). For example, participant 11 distracted herself from rising distress by feeling the cold window on her hand: “I put my hand on the cold window and I’m counting in my head and be steady breathing. And try not make much eye contact with people if I’m looking out of the window if I’m lucky enough.” Thus, disengagement strategies had positive qualities and a vital purpose (i.e., gaining breathing space) that should not be disregarded. Therefore, whether disengagement is adaptive or maladaptive depends on the context (Naragon-Gainey et al., 2017). In fact, strategies, such as avoiding people or suppressing feelings, may be vital when survivors have no internal or external resources available to help them understand or address situations. Notably, survivors of the present study practiced disengagement largely if they were in an isolated situation with no supportive others available as an external resource. Naragon-Gainey et al. (2017) suggested that lack of these external resources may be the reason why some survivors had a low tolerance of distress that led them to utilise disengagement readily. Disengagement, Nawijin et al. (2015) also argued, may be appealing because it requires little effort and can be adopted quickly. The findings of the present study suggested that disengagement strategies yielded short-term benefits, such as reducing overwhelming distress, making life (temporarily) manageable, sometimes creating the space to reflect and find longer-term solutions, or enabling the survivor to prioritise other pressing issues.
4.3.2. Making invisible experiences visible

A second key strategy among survivors was to make invisible internal feelings, thoughts, needs and other aspects related to traumatic experiences external and visible. Survivors from both the community and the clinical site did this in several ways. For example, some participants wrote poetry or journals, took images, exercised, meditated, or listened to music to capture their feelings and ‘get them out’. Participant 06 reported “I used to do writing therapy for myself when I had nobody to talk to or rage at. I used to sit and write.” Similarly, reading books, blogs or websites, and watching online videos about trauma and abuse enabled survivors to identify and name their abuse and day-to-day difficulties related to trauma. Also, talking to supportive others about one’s abuse, trauma and recovery, and finding words to describe these experiences was important. Participant 06 illustrated that talking to a counsellor “allowed me to see how bad it was. How dysfunctional it was because it, it allowed me to put my cards on the table and look at them, I think. And see everything.” In turn, internal experiences came to the surface when health professionals, peers or friends shared information about abuse and trauma, and when they labelled survivors’ experiences. In this respect, participant 04 remembered “She [her community psychiatric nurse] just said ‘It sounds like you’ve got flashbacks.’ ... I couldn’t have identified it for me because it’s almost like trying to look at part of your body you can’t see” and “Until someone said ‘You might have posttraumatic stress.’ I had no idea.” Also, several survivors reported identifying with the negative thoughts, distressed feelings, or traumatic life experiences that their peers in support or therapy groups disclosed: “But it was more the anxiety. More the challenges of every day, that I started to identify with.” (Participant 08).

Making the invisible visible was driven by a need to ‘get it out’. Participant 01 illustrated this: “I would pick up the phone to her at two, three in the morning. She didnae care, ken. And she would listen to me for hours on end, ken. Or if I was erratic and emotional and I’m, like, sobbing. She would let me. She just wouldnae say anything. She
Several survivors articulated this ‘getting it out’. It suggested that they experienced a mounting tension by holding their traumatic experiences and day-to-day difficulties inside.

Previous research evidence has suggested that suppressed thoughts, feelings, behaviours and traumatic experiences are associated with physiological changes in the body and greater activity in the autonomic nervous system (Pennebaker & Francis, 1996). In my study, this may explain participants’ need to release such control by making thoughts, feelings and experiences visible. Correspondingly, there has been other evidence that activities, such as exercise, writing or talking, do in deed ameliorate physiological changes and symptoms due to repressing emotional distress. For example, LeBouthillier, Fetzner, and Asmundson (2016) showed that aerobic exercise reduces PTSD. A possible mechanism may be that survivors begin to adjust to physical responses to anxiety and stress because the same reactions are experienced during exercise (e.g., greater heart rate, sweating, rapid breathing). Thus, misconceptions about those reactions being indicative solely of danger are challenged (LeBouthillier et al., 2016). Similarly, Nolan (2016) showed that trauma-sensitive yoga reduced PTSD, as well as depression and anxiety in female interpersonal trauma survivors because of its ability to reduce secretion of the stress hormone cortisol while increasing the inhibitory neurotransmitter GABA, and reducing fluctuations in heart rate such that the autonomic nervous system is rebalanced. Pascual-Leone, Yeryomenko, Morrison, Arnold, and Kramer (2016) found that expressive writing about a traumatic event initially increased emotions after each session, but over time these decreased. Thus, expressive writing might have a self-regulatory function and, like exposure therapy, help to block negative thoughts and feelings through repeated exposure (Frattaroli, 2006).

In this study, making internal thoughts, feelings and memories visible or external yielded several results for participants. Firstly, talking, listening, reading, and
writing about trauma as well as engaging in exercise and creative activities enabled awareness and focus that was previously absent. For example, participant 04 adopted a ‘hellraiser scale’ to help her talk about confusing experiences of flashbacks: “It’s just an acknowledgement. (It can) get outside of me a little bit. You know. Of me saying ‘I’m in the Hellraiser and it’s scale 8’. Saying it makes it feel like a physical thing that I can deal with. You know. I know it’s not. But it gives me a sense of that. A bit like when you talk to the doctor and you go ‘Oh my arm is really sore. Look.’ It’s almost like I’m doing that when I say ‘This is how I feel. I’m in Hellraiser, scale 10.’” Bringing trauma, feelings, thoughts, and other internal experiences to the surface began the process of understanding and making sense. What is more, expressing one’s distress, that is making it visible to others, elicited support, comfort and validation. On the one hand, survivors reported that making distress visible calmed down, and brought relief, strength, courage, hope and freedom. It was emotionally liberating and released physiological distress. On the other hand, they reported that gained insight could be frightening. Finally, externalising one’s internal experience – whether in writing, pictures or speech – brought the advantage that it could be looked at and examined.

Strategies to make internal experiences visible appeared to have a mindfulness-like qualities. Generally, mindfulness is understood as “disengaging from negative states of mind” (Garland et al., 2015, p. 2), being in the present moment without evaluating it (Naragon-Gainey et al., 2017; Pagnini, Bercovitz, & Langer, 2016), and becoming aware by attending to an experience on purpose (Kabat-Zinn, 2003). In this respect, taking pictures, writing, exercising, listening to music, and doing art or knitting appeared to help the survivors to take their mind off distress and, instead, to focus their attention on current images, movements of pen on paper, bodily reactions, or haptic sensations. However, Garland et al. (2015) suggested that this understanding of mindfulness is incomplete. They argued that, while mindfulness techniques enable people to detach from negative cognition and emotion, the distance also creates breathing space and new insights which, in turn, makes
habitual but largely unconscious cognitive, emotional or behavioural responses visible. In my study, taking pictures, writing, exercising, and doing art or knitting appeared to bring to mind feelings, thoughts or experiences, but did so in a non-threatening way that allowed them to be re-assessed. For instance, participant 01 began to assign meaning to her photographs “I had started taking pictures of, like, prison bars on windows because I felt like I was in jail. And knots down at the harbour because it was like, my stomach was always in knots.”; participant 06 began to see her difficult situation more clearly after writing it down; and participant 14 began to feel a sense of achievement when knitting “even if I couldn’t get out of bed, you know, couldn’t face doing anything, at least by the end of the day I had a hat. … At least I had accomplished something.” Facing one’s negative emotions alone or looking at oneself alone and at the impact of personal trauma experiences appeared to be too threatening so that survivors tended to disengage. On the other hand, physical or creative activities provided a way to approach distress more gently, particularly when no support was available.

4.3.3. Examining one’s life in relation to abuse and trauma

As a third strategy, participants looked in detail at their everyday difficulties, emotional distress, effects on oneself from interactions with other people, and sometimes the abuse experience. Participants examined these elements by questioning and being questioned, by tracing difficulties back to stressful events in the past, by reading or writing or hearing others speak about trauma, by comparing and differentiating their experience (e.g., trauma, or feelings) with those of others, and by gradually testing out if others can be trusted. In this respect, writing or taking pictures was reported several times as enabling reflective processes and allowing people to investigate reasons for behaviours, for example, for one’s drinking or self-blame. In this respect, Pennebaker and Francis’ (1996, p. 622) study showed that writing about stressful events led to using more “insight-related and
causal words”, suggesting that their participants formed more ‘coherent narratives’. In a similar way, participants in the current study appeared to construct a clearer account of their traumatic experience when examining it. Reading books and websites, or watching online videos about trauma, abuse, the brain or coping strategies was also found to be helpful because it provided explanations, practical advice and different perspectives. This ‘demystified’ traumatic experiences: “I think it just demystifies and take the fear out of thing, if you actually look further into it, and getting more knowledge” (participant 02).

In particular, supportive others appeared to facilitate self-examination, for example, when they enquired about the survivor’s day-to-day difficulties, their feelings, perceptions, reaction, and the experience of abuse, but also by providing information on these or affirming survivors’ experiences. For instance, participant 13 was asked in a therapy group ‘How do you feel [physically] when you are anxious?’ which prompted her to assess what was happening to her body. For participant 12 it was helpful “to [be] explain[ed] that it wasn’t acceptable to put up with that sort of (?). You know, the physical and sexual abuse. It wasn’t normal.” It seemed that comparing one’s feelings, and relationship or life experience with those of other trauma survivors or with those experiences associated scientifically with trauma provided an important point of reference for survivors – a hook to hold on to. Their day-to-day difficulties began to make sense to them. Examining one’s situation in relation to abuse and trauma was, at times, experienced as challenging because it resulted in intrusive (as opposed to intentional) rumination – “Sometimes it [flashbacks, trauma memories] will happen obviously when I’m by myself. And then I think about it. I spend time inside my own head exploring it and thinking about it. And I don’t think that’s good. That’s not good for me.” (Participant 06) – or survivors resisted thought-provoking and confrontational material, such as participant 03 who felt alarmed when being asked by someone (health professional) for the first time about how she felt – “I says ‘What do you mean how do I feel?!’ Cause I was very defensive.” However, it was also experienced as soothing by some.
In this sense, ‘examining one’s life in relation to abuse and trauma’ is indicative of the cognitive processing and restructuring discussed in previous literature (e.g., Ehlers & Clark, 2000; Larsen & Berenbaum, 2015; Turliuc et al., 2015). ‘Examining’ also seemed to indicate a process of assessing the information that had been made visible with respect to whether it could be assimilated into the survivor’s pre-existing view of self, trauma and the world without altering this view, or should be accommodated by changing one’s assumptions (Joseph et al., 2012). A key distinction is drawn in the literature between brooding and reflecting, or between intrusive and deliberate rumination (Stockton et al., 2011). Some research evidence has suggested that the former signals adaptive coping and the latter maladaptive coping based on lower or higher levels of post-traumatic stress (Ehring & Ehlers, 2014; Kamijo & Yukawa, 2015; Stockton et al., 2011; Turliuc et al., 2015). However, these studies disregard the context in which those coping strategies are used. Findings in the present study suggested that both intrusive repetitive as well as deliberate forms of ‘examining’ were used by survivors as their way to work through traumatic experiences. The difference may lie in ‘examining one’s life’ by oneself or with others. In other words, intrusive repetitive processing – predominantly practiced alone – may occur because the survivor did not have access to alternative perspectives that could alter this cycle. On the other hand, supportive others or mindfulness-like activities could provide alternative viewpoints prompting more reflective and deliberate processing in the survivor.

4.3.4. Reconstructing reality

Finally, survivors reconstructed their perceived reality about (a) abuse and trauma, (b) choice and control, (c) themselves as person, and (d) their responsibility for abuse and recovery.
Reframing abuse and trauma

Abuse and subsequent trauma came to be understood differently over time: (1) Initially, abuse was not recognised as abuse and, instead, seemed to be understood as the survivors’ fault, as deserved, as normal and legitimate. Gradually, it became reconstructed as not normal, as abusive, and not their fault. For example, participant 11 expressed that “I only ever believed the only thing good for me would be rape” and participant 08 reported “I didn’t see it as rape.” (2) Initially, survivors believed that they would continue to suffer, that their day-to-day difficulties would never cease, or that everyone experiences these difficulties regardless of abuse and they were the only person unable to cope. However, day-to-day difficulties were reframed gradually as normal reactions to an abnormal experience and survivors learned that these difficulties can cease. For instance, participant 14 stated “I didn’t know there was anything wrong [with me]. I just thought that’s how everybody lived. Sort of, terrified.” (3) Similarly, survivors initially assumed that their difficulties were multiple, distinct problems, and addressing these separately could become overwhelming. However, when this ‘mess’ became reconstructed as multiple efforts to manage current distress which had its root in a single source, namely the abusive experience, people coped better. For example, survivors began to attribute their experiences of abusive intimate relationships in adulthood to their experience of abuse in childhood, they began to view their addiction as a way to cope with trauma from abuse, or recognised that a family member or former partner was abusive. For example, participant 13 reported “I was just anxious around … noise. And just feeling depressed as well. Feeling exhausted by it. And things like not getting proper sleep and, (things) I think. But, well, I know now it is part of trauma.”

Reframing abuse and trauma in this study is similar to concepts of cognitive reconstructing, reappraisal or meaning-making highlighted in previous literature. For example, Ehlers and Clark (2000) proposed in their cognitive model of PTSD that recovery requires cognitive reconstruction of ‘excessive negative appraisal’ of the traumatic event(s) and its subsequent trauma-related difficulties. Also, Joseph et
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al. (2012) suggested that distressing emotions require to be normalised and that the meaning of events requires reassessing and changing. Concepts of re-constructing, re-appraisal and meaning-making would suggest that abuse and trauma were initially blocked or differently constructed and appraised before being re-made. In contrast to the incomplete explanations provided in previous literature, the findings from this study shed light on what the initial perspectives were and what the reconstructed content became, as well as how it was reconstructed – namely through a process of reduced disengagement strategies, and increased efforts to make experiences visible, examine one’s life in relation to abuse and trauma experiences and reframe these experiences. While this was predominantly mental work by survivors, the study findings also showed the importance of them using input from supportive others as new reference points which helped change the survivors’ perceptions of traumatic experiences. Thus, reframing abuse and trauma was also relational, referential and contextual (Leontiev, 2016).

Reconstructing choices and control

Survivors’ sense of choice and control in their lives came to be understood differently: Initially, their past experiences of an abusive and neglectful upbringing, and of abuse in adulthood was constructed as environment of little choice and personal control. For example, they mentioned repeated experiences of having been manipulated and rigidly controlled by adults. Others described taking charge as child in situations that would require an adult because no adult was available, or of pretending that everything was fine because caregivers did not acknowledge the child’s distress. These patterns of external control or lack of control continued into adulthood. Adult survivors reported having had manipulating, controlling, chaotic and abusive intimate relationships where they pretended to be in control of their life, or they rigidly controlled a small comfort zone. In this respect, participant 14 stated “So I feel like I’ve got this little pocket of normal life, if you like. Very small, and very … contained. But within that, I’m able to – if nothing rocks the boat, you know, if nothing big happens, or, you know, if I’m not expected to have to do anything … in particular, that’s
outside my comfort zone – I can have this little pocket of normal life where I feel okay.”

Some participants reported that it did not occur to them that they had a choice in those circumstances (e.g., participant 11, 12, 14). Other participants reported that they did not have any effective strategies available to help them cope with the abuse and the distress, which limited their options and their sense of control (e.g., participant 11, 12, 14, 15).

Survivors attempted to regain some control in several ways. For example, taking alcohol and drugs made distressing situations manageable to a certain extent. Distracting oneself kept distress at bay. Ending non-abusive relationships or making the other person leave helped to stop feelings of distrust and anxiety. Saying ‘yes’ or nothing to other people’s requests and being ‘too nice’ helped to prevent further abuse. However, these various attempts to gain control – while somewhat effective – also resulted in less control: substance misuse led to emotional, relational and physical problems; distraction became avoidance and unaddressed distress resurfaced; and saying ‘yes’ led to being exploited. There was a sense of helplessness because any action seemed to lead to negative outcomes. Therefore, people still had little sense of control or choice. Participant 10 illustrated her ambiguous sense of control: “I knew that … I wasn’t in control, like, I already knew that. No! I didn’t know that actually. I’m talking crap. I did not know that I wasn’t in control.”

Yet, some participants did report gaining more control and having choices in life. This was characterised by reducing attempts to control external factors, such as one’s environment or relationships, and instead deciding to look after oneself first, wanting to get better, and receiving help from others. For example, participant 01 stated “Think I started to realise that the only person that could help me, was me.”, and participant 11 added “But if you [make] the decision to look after yourself then there’s beautiful things that you can witness as well.” Supportive others enhanced survivors’ sense of control by explaining situations and internal reactions to them, and by suggesting or demonstrating alternative ways of coping.
These findings are supported by previous research. Stige et al. (2013), for instance, found that female trauma survivors became problem-solvers for others as an initial strategy to enable them to gain a sense of control, but then lost their ability to make choices over whether to help or not to help others. Domhardt et al. (2015) has discussed research identifying an internal locus of control as a protective factor for mental well-being while an external locus of control could damage resilience. Munford and Sanders (2015) reported that it was important for adolescents with adverse childhood experiences to develop strategies of ‘acting on the world’. In this respect, relationships with significant others contributed important resources and validation which provided these young people with more choices and options for constructive thinking and behaving. Developing this sense of agency was also important to participants in this study.

_Reconstructing beliefs about oneself_

Survivors’ beliefs about themselves came to be understood differently. Initially, all 15 survivors repeatedly reported perceiving themselves as inadequate. This was articulated as believing oneself to be stupid, mad, crazy, a bad person, a failure, not good enough, worth ‘less than’, insecure, ruined, disgusting, too nice and giving, an embarrassment to others, and deserving of a difficult life. Such feelings of shame indicated low self-worth. Budden (2009) suggested that shame is a key emotion underlying post-traumatic stress, and it rewrites a person’s core identity and integrity within the social environment. While relinquishing shame may serve the function of repairing a person’s social self where status and social connections have been lost, shame can become problematic when this repair does not appear to be possible (Budden, 2009; Cibich, Woodyatt, & Wenzel, 2016). A review by Kennedy and Prock (2016) also showed that self-blame, shame and anticipatory stigma prevent survivors of childhood sexual abuse, sexual assault and intimate partner violence from disclosing and seeking help. Non-disclosure and avoiding help-seeking may increase their sense of worthlessness further.
The identity of participants in the current study was constructed around an abusive past where others made them feel inadequate. Participant 02 remembered: “For years before that I’d always thought I was a bad person like my mother had told me all my life. And was still up to that time doing that.” As a result of feeling inadequate, they distrusted the critical thinking that may be required for ‘making visible’ and ‘examining’ their traumatic life experiences, they doubted their personal needs that may have motivated them to pursue changes; and they doubted their capability to make effective change happen. For instance, participant 03 illustrated: “I was always wanting to ‘What do you think?’ So that you would make the decision. … I was always putting, ken like ‘Oh, I want to do what you do.’” They appeared to have given up on themselves, isolating themselves, and using ‘disengagement’ strategies because it was too painful to look at one’s inadequate self.

Survivors gradually did reconstruct their identity. Actions reported under ‘making invisible experiences visible’ and ‘examining one’s life in relation to abuse and trauma’ helped make the invisible-inadequate-self visible, while enabling participants to question and assess its accuracy and explore a more adequate self. For instance, gaining breathing space, pursuing creative activities and practicing positive self-talk were ways to nurture a worthy self. Tracing back and linking one’s self-worth to past abuse, beginning to review one’s own role in day-to-day difficulties, and having negative beliefs challenged by others were ways to look at and examine oneself. These mental activities, that facilitated a shift from an inadequate to a valuable self, were signs of increased reflective functioning and that has been associated with ‘identity formation’ by Fonagy, Gergely, Jurist, and Target (2004) and Fonagy and Target (2006). Also, having compassion for oneself has been linked to a reduction in post-traumatic stress and emotional difficulties (Barlow et al., 2017).

In particular, supportive others contributed positively to a shift in survivors’ self-worth when they listened without judgment, when they comforted, validated,
protected, guided and understood the survivor. Their active involvement seemed to communicate ‘you’re worth it’. Participant 08 remembered entering a trauma service for the first time and a staff member sat next to her inviting her to attend a trauma group the same day: “something happened that day and, you know, I continually say < that staff member > took my hand that day and she has never let go. And, you know, everybody in that < service > is, you know, amazing. And it really has saved my life to where I am. … Something inside shifted and, you know, there was a connection …”.

Eventually, survivors reconstructed an adequate self that they described as being valued, strong, in control, and able to choose. Perceiving themselves as worthy allowed them to take better care of themselves, to feel grateful for today, to forgive self and others and what had happened, and to engage in living life: “But I can probably remember the day when my thinking changed. Like looking in the mirror and saying ‘Do you know something? I’m worth this. I can do it.’ And that was probably when I went back to the < specialist treatment centre >. Cause I hadnae been engaging with therapists on one-to-one. And I went back.” (Participant 05).

The impact of traumatic experiences on changes in the self, personality or identify has been documented widely (e.g, Ehlers & Clark, 2000; Horowitz & Sicilia, 2016; Kerr, Finlayson-Short, McCutcheon, Beard, & Chanen, 2015; Pratchett & Yehuda, 2011; Resick et al., 2012). Therefore, it is not surprising for it to emerge in this study. Also, the experiences described by participants in this study of an ‘inadequate self’ have been conceptualised elsewhere as ‘mental death’ (Ebert & Dyck, 2004), ‘mental contamination’ (Badour, Feldner, Babson, Blumenthal, & Dutton, 2013; Badour, Ojserkis, McKay, & Feldner, 2014), or a dissociated, disconnected self (Bob & Laker, 2016). Cognitive restructuring has been regarded as the main strategy that enables people to transform this inadequate self into a valuable self (Ehlers & Clark, 2000) and, to a certain extent, this was confirmed in the findings of this study when participants reported using positive self-talk, for example. Yet, the study findings also stressed the role of supportive others who communicated worthiness to the
survivors. Thus, the reconstruction of how survivors saw themselves as a person was also a relational process.

**Shifting and sharing responsibility for abuse and recovery**

Finally, the survivors' sense of responsibility for abuse and recovery came to be understood differently. Initially, most survivors believed that it was their fault when another person (the abuser) hit them, molested them, dismissed them, or insulted or shouted at them. They also believed that it was their fault when they were unable to manage life afterwards. This was evident in their numerous accounts of blaming themselves for what had happened in the past and for their present struggles. For instance, participant 09 reported that she blamed herself when she had been exploited by two peers she had trusted “I’ve been taken for a total twat again. And I’ve let it happen to myself. It’s my fault.” Equally, participant 15 reported blaming herself when not coping as adult: “when you’re not coping, you tend to think that it’s your fault, because you should be able to cope. And if you’re feeling you’re, like, not coping then I tend to blame myself.” It suggested that they felt responsible for both the abuse and their current inability to manage life’s challenges. This is supported by previous research evidence showing an association between guilt and post-traumatic stress (e.g., systematic review by Pugh, Taylor, & Berry, 2015). Another review has found that self-blame predicted revictimisation of survivors of childhood sexual abuse, sexual assault and intimate partner violence and that self-blame showed a bi-directional link over time with negative social reactions (Kennedy & Prock, 2016). In this study, participants talked about revictimisation alongside negative social support and these factors may have further exacerbated a sense of self-blame and responsibility in these survivors. Abo-Zena (2017) suggested that some perpetrators of interpersonal violence might justify their harmful behaviour, thus liberating themselves from blame and instead ‘displacing responsibility and blameworthiness’ onto another person. Perhaps participants in this study accepted this responsibility. An alternative theory is the Just-World-Hypothesis which postulated that bad events happen to bad people (Lerner & Miller, 1978). Since participants in the
present study had experienced abuse and were not managing their day-to-day life they may have assumed that they must have done (or must be doing) something wrong. In addition, the cultural beliefs surrounding the participants may have placed responsibility for abuse and subsequent trauma onto these individuals, as suggested by Shaw, Mclean, Taylor, Swartout, and Querna (2016).

This double responsibility was lifted when participants’ past experiences were reframed as abusive event and when their present day-to-day difficulties were understood as traumatic responses. Responsibility for the abuse was shifted from the survivor onto the person who harmed or neglected them. This was evident when survivors blamed people who they identified as a perpetrator (e.g., the sexually abusive stepfather, the alcoholic narcissistic mother, the absent father). For instance, participant 11 reported after being sexually assaulted and ignored within her family: “And no one’s ever taken some responsibility. But he [a relative] doesn’t know the extent and the pain. And, like, take my parents, they’ve taken no responsibility as well. Do you know what I mean? None of them take! None of them takes; none of them can take (a tin for it). It’s all me.” Also, responsibility for managing present day-to-day difficulties was shared once supportive others were actively contributing to the survivor’s recovery. To the participants, they seemed to do so by reaching out to them, listening, questioning, explaining, believing survivors’ story, actively getting involved, but also providing a safe breathing space. This ‘being there’ for participants lifted part of what was previously seen as a sole responsibility for recovery by survivors and became a shared undertaking between survivors and supportive others. This is not to say that others were viewed as solely responsible for fixing trauma survivors’ problems. In fact, several survivors reported that “you really got to help yourself mentally!” (participant 12) and “I started to realise that the only person that could help me, was me.” (participant 01), indicating that wanting to get well and putting in hard work is a survivor’s own responsibility. Equally, some participants reported that they began to take responsibility of their own action and inaction: “But I turned into an abuser. Like, I physically and mentally assaulted my pals. I mentally abused < a family member > for money.
So I had become what I resented in people. But also knowing what I didnae want and that’s why I stay clean. Didn’t want to go back to that.” (participant 05). Lifting this double burden of abuse and trauma increased survivors’ resources for managing their day-to-day difficulties and beginning to participate more fully in life. Lessening self-blame through reassigning responsibility may have also reduced survivors’ sense of shame and increased their self-worth. Trauma literature discussing this ‘shared responsibility’ is limited. More recently, a few authors have suggested that instead of individual-focused approaches to trauma, ecological approaches are required to address contributory factors arising from the social system in which trauma survivors are living (e.g., Bryant, 2016; Maercker & Hecker, 2016; Shaw et al., 2016). However, this appears to be a new development in the field. The findings presented here indicate that investigating how supportive others and a supportive environment can shift responsibilities merits further investigation.

4.4. Grounded theory of trauma recovery

These key components of the experience of living through trauma do not function in isolation. Instead, they affect and interact with one another and can be integrated to form a coherent theory of trauma recovery with a focus on emotional and interpersonal functioning. The following section will build this theory step by step, beginning with the abuse and trauma symptoms. Then the four key components of ‘disengaging from feelings, people, and self’, ‘making invisible experiences visible’, ‘examining one’s life in relation to abuse and trauma’ and ‘reconstructing reality’ will be added and placed in two frameworks: (1) self-management navigated by the survivor on their own and (2) self-management navigated by the survivor with the support of others. Finally, the theory will conclude by reaching the phase of recovery. Figure 7 shows the full diagrammatic model.
Figure 7. Social reconstruction model of trauma recovery
4.4.1. Constructing a negative reality from abuse

Most participants reported some form of abuse or neglect in childhood. Frequently, maltreatment occurred within the family environment and included, for example,

- sexual abuse by fathers or stepfathers
- sexual and physical assault by brothers
- not being believed when disclosing sexual abuse to another family member
- an emotionally or physically absent father
- emotional abuse whereby a caregiver threatened or was verbally abusive or whereby a single mother’s male visitors exploited the child
- emotional neglect whereby caregivers told the child that she overreacted and made up a problem or whereby caregivers did not cuddle or kiss the child or ask the child how she felt

In addition, learning of a caregiver’s death, witnessing violence between parents, and having adult responsibilities as a child (e.g., “I always knew that if I wasn’t … in charge, nobody else was ever going to be in charge.” Participant 14) were expressed as traumatic experiences. Occasionally, participants spoke of sexual abuse by a stranger (which they felt unable to disclose to controlling caregivers), witnessing another woman’s rape, or of emotional neglect in institutional care. Overall, participant reported an ongoing unpredictable, violent and dismissive environment during their formative years. Over time, participants constructed a reality shaped by prolonged suffering from abuse with three profoundly negative beliefs consistent with their own low self-worth (Figure 8):

I have little choice and control.
I am a bad, stupid, weak person and deserve no better.
It’s my fault; I am responsible.
Repeated exposure to abuse in adulthood nourished these existing negative beliefs. The trauma literature has described these incidents as traumatic events, and particularly interpersonal violence, and has associated them with the development of complex trauma symptoms and ineffective ways to cope (e.g., American Psychiatric Association, 2007; Cloitre et al., 2013, 2005; Courtois, 2014; Ehring & Quack, 2010; Ford et al., 2005, 2006; Herman, 1992; van der Kolk et al., 2005). In the current study, emotional difficulties reported by participants included, for instance, unmanageable anxiety, shame, numbness and confusion. Interpersonal difficulties included isolating, distrusting others, or being ‘too nice’. Additionally, participants reported having flashbacks, chronic physical illnesses, a negative belief system, and comorbid symptoms (e.g., substance misuse, self-harm, suicidality, depression, dissociation).

Figure 8. Constructing a negative reality from an abusive environment
4.4.2. Day-to-day difficulties indicative of ‘disengagement’

When exploring participants’ day-to-day difficulties in more detail, they appeared to be attempts to cope, and predominantly by disengaging from feelings, other people and one’s self. Participants sought to disengage from uncomfortable feelings, interpersonal contact and looking at themselves. This escape appeared to reduce further suffering: For example, numbing uncomfortable feelings reduced survivors’ intense, complex and frequent emotional suffering; it provided a breathing space, restored their internal balance, and helped manage their daily life. Getting away from people reduced the risk of being hurt again by others and it increased safety and personal space. In addition, not facing traumatic experiences reduced distressing memories, and upsetting feelings that came from having to engage with a self-image that was perceived as deeply inadequate.

Distancing can be an inventive and, to a degree, effective emotional and practical coping strategy. Yet, it has negative consequences. Substance misuse, for instance, gives temporary respite but eventually added emotional, relational and physical health problems. Self-harm produced only temporary emotional relief but can be life threatening. Accumulated and unaddressed negative feelings resulted in emotional outbursts and breakdowns. Isolating oneself from other people caused feelings of loneliness and abandonment. By not looking at their trauma, abuse and inadequate self, participants continued to contribute to their ongoing suffering. The tensions between the benefits and costs of ‘disengaging’ were illustrated by participant 12 who stated “there was a stage in my life when I let everybody in. And I got really hurt. … So after that I just went ‘No!’ … I’d just stay with myself and then nobody is getting in and nobody can hurt me. And the only person I’ve got to answer to is myself. So. Right. Which isn’t good either because it cuts you off.” Relying on disengagement strategies meant that survivors addressed their day-to-day difficulties in isolation without seeking or accepting support. Yet, other disengagement strategies, such as exercising, taking pictures and meditating, were associated by survivors with positive feelings,
reduced suffering, and did not seem to complicate life long-term. When looking closer, these more creative and positive activities facilitated a gradual looking at oneself (as opposed to directly facing one’s trauma experiences and low self-worth). They made other internal experiences visible. Before I expand on this second strategy, a key challenge needs to be highlighted. Figure 9 shows added components to the diagrammatic model.

![Figure 9](image.png)

*Figure 9. ‘Disengagement’ initially reduces and eventually increases suffering*

While all ‘disengagement’ strategies provided immediate relief, it was not obvious to survivors when this immediate temporary relief caused long-term complications until problems arose. Nor did they identify helpful behaviours that contributed to long-term recovery. Also, it was not obvious to survivors that the suffering they attempted to disengage from did not originate from multiple, distinct difficulties (e.g., flashback, dominating negative feelings, alcohol consumption, abusive adult relationships, negative self-perception), but from one issue (namely, abuse with subsequent trauma). This was problematic for two reasons: Firstly, efforts to cope
were spread too thinly across many ‘disengagement’ strategies, making it difficult for survivors to assess what strategies were working long-term. Other studies found similar observations where adjusted survivors focused on a few coping strategies only, and maladjusted survivors “distributed their coping efforts, and so [did] not focus primarily on the most adaptive strategies” (Oaksford & Frude, 2003, p. 55).

Secondly, repeated ‘disengagement’ – disguised in drinking, taking drugs, isolating, self-harm, exercising, taking pictures etc. – became the default strategy and, by the time complications of some of these behaviours were obvious, it was difficult to change maladaptive habits.

4.4.3. Relationship between ‘disengaging’ and ‘making invisible experiences visible’

Whereas extensive use of ‘disengagement’ strategies increased suffering long-term because unaddressed trauma was kept hidden and suppressed, doing the opposite could be a beneficial alternative step towards recovery. Indeed, survivors pursued activities that made their hidden experiences more visible. Some ‘disengagement’ strategies had this quality: For example, survivors took pictures of outdoor environments to escape distress and calm down. While it released distress it also refocused survivors’ attention back on themselves when they assigned meaning to those pictures that represented their feelings or their trauma. Yet, there were also non-avoidant strategies, such as writing journals about their feelings and about distressing life experiences, or readings books about trauma. On the one hand, making previously suppressed experiences visible released the tension inside – they ‘got it out’ – and, on the other hand, it made survivors more aware of negative feelings, abuse and trauma. This, in turn, enabled them to examine their situation. These creative activities appeared to have elements of mindfulness in that they enabled survivors to focus their attention on present moments and, thus, bring the present into awareness (Kabat-Zinn, 2003). A review by Banks, Newman, and
Saleem (2015) found evidence that mindfulness-based approaches for PTSD reduced avoidant coping, hyperarousal and re-experiencing. It could be suggested that other techniques, such as taking pictures, knitting or writing have the same function.

If survivors brought invisible experiences to the surface by themselves, this could be problematic for two reasons: Firstly, releasing tension and gaining awareness of traumatic content generated further anxiety, shame, and confusion at times. Similar mechanisms have been suggested by Banks et al.’ (2015) whereby mindfulness-based approaches to PTSD might increase awareness of one’s emotions, thoughts and bodily experiences and then produce flashbacks, dissociation, and intrusive thoughts and memories. To participants in the current study, this might indicate that making underlying issues visible is ineffective or harmful. Secondly, the distress and apparent ineffectiveness of self-management techniques confirmed the previously constructed beliefs of ‘I have no control’, ‘I must be weak and stupid’ and ‘I am responsible for failing’. There were no other resources or supportive others available to relieve or explain the emotional pain resulting from making traumatic experiences visible, or to challenge negative beliefs. Consequently, this strategy (‘making invisible experiences visible’) did not always work for survivors and then they resumed ‘disengagement’ strategies. This is visualised in Figure 10.
4.4.4. Relationship between ‘disengagement’, ‘making invisible experiences visible’ and ‘examining one’s life in relation to abuse and trauma’

Making invisible experiences visible facilitated an examination of oneself and the environment in relation to the experienced abuse and subsequent trauma, and this was reported as relevant by survivors. Initially, survivors examined issues on their own. That is, they read, wrote, and thought about trauma-related material (such as abuse, day-to-day difficulties, coping strategies or how life circumstances affected them) without seeking help from people. In turn, this examination uncovered further hidden experiences. For example, participant 02 reported reading books...
about trauma and abuse by academic writers. Case stories and discussions in these books had similarities to her own childhood trauma; so she began to identify – make visible – her traumatic past. Information in those books also explained and helped her examine her current day-to-day difficulties. Consequently, she continued reading other materials (e.g., other books, websites) on the topic of childhood maltreatment (‘examining’) which, in turn, made further aspects of her past trauma visible to her.

This example showed that the strategies ‘making invisible experiences visible’ and ‘examining’ these closely interact. However, this does not always occur: ‘Making invisible experiences visible’ did not always lead to ‘examining one’s life in relation to abuse and trauma’. For instance, when participants felt too distressed by what surfaced instead of examining, they disengaged. ‘Examining’ implied that survivors actively pursued what had surfaced. In respect to this study, participants queried surfaced experiences further; they questioned them; they tried to find out more through reading or writing; they traced day-to-day difficulties back to the past; and they compared different cases. Instead of distancing themselves from past trauma, they engaged in making sense.

While there was a sense that examining one’s life in relation to experienced abuse and subsequent trauma moved survivors forward in the long-term, the process of it was not always a positive experience. That is, similar to ‘making invisible experiences visible’, ‘examining’ sometimes uncovered information, ideas and emotions that made survivors upset, confirmed their negative beliefs and, therefore, signalled to them that it was not an effective strategy. Once again, other support was not available to survivors and this implied that managing these difficulties by themselves could not help them cope with the demands of bringing a hidden past into the open. As a result, ‘disengagement’ strategies became a viable option again. Figure 11 extends the evolving model.
4.4.5. The reality and suffering reconstructed by abuse is not effective

The extent to which survivors could achieve recovery from the trauma of abuse by themselves was limited. Disengaging from trauma-related material (including emotional pain and relationships to abusers, partners and people generally) dominated as coping strategy and, while bringing relieve short-term, did not improve life circumstances long-term. On the one hand, making trauma-related material visible and then examining it released distress and brought valuable insights. On the other hand, these positive outcomes were offset when they led to a further cycle of unmanageable distress. Therefore, survivors appeared to move back...
and forth through these three strategies without making significant progress towards recovery.

There were several other problems to ‘doing recovery’ solely by oneself. Firstly, recovery took a long time. Several participants with a history of child abuse were over 30 years of age, still suffered from the effects of abuse and had only sought support more recently. The current findings also suggested that they tried to manage the effects by themselves for many years, sometimes decades. This is supported by other studies. For example, Allnock and Miller (2013) reported that survivors disclosed, and therefore may seek help specifically for trauma, on average 7.8 years after the abuse, with 18 years being longest. Kogan (2004) and Smith et al. (2000) have reported that 26% to 28% of survivors never disclose their abuse.

Secondly, it was difficult to distinguish between maladaptive and adaptive strategies because any strategy survivors explored often had positive and negative repercussions and because short-term relief was achieved from long-term ineffective strategies. Difficulties to distinguish strategies risked that a vast range of strategies were employed and, while doing so, survivors could not focus on those few strategies that would be effective long-term. Similar observations were reported in other studies. For example, Oaksford and Frude (2003) showed that the focused use of one or two coping strategies was more effective than the dispersed use of many different coping strategies in adult survivors of childhood sexual abuse. Shipman, Edwards, Brown, Swisher, and Jennings (2005, p. 1023) found that neglected children had “fewer adaptive emotion regulation skills, and less effective coping strategies than their nonmaltreated peers”.

Thirdly, dealing with the effects of trauma in isolation required a considerable amount of effort and personal strength. Survivors with ongoing day-to-day difficulties were not in a strong position emotionally to begin with and frequently lacked the necessary resources to make difficult experiences visible, examine them,
handle the emotional repercussions, and make sense of past abuse and trauma. They then needed to be robust enough to gain choice and control, construct self-worth, and shift responsibility. Participant 13, for example, reported feeling exhausted from being alone with her negative thoughts and that it required an external resource (i.e., support from a health professional) to normalise these day-to-day difficulties for her: “It made me feel that like ‘No. You’re not mad. And I’m not alone … in those thoughts.’ Because it is quite exhausting.” Thus, getting external support would allow to share effort and resources. This observation supports the Social Baseline Theory which suggests that humans are wired to seek out social proximity with others in order to conserve energy for better survival and protection from threat (Bryant, 2016). The fact that survivors in this study disengaged from social connections may have been their way of conserving energy that was required with abusive others.

In addition, survivors did not realise by themselves that most of their current difficulties, such as addiction problems, flashbacks, emotional distress or numbness, and isolation, had one source – namely, that they were normal responses to being traumatised from an abusive experience. Therefore, difficulties appeared to them like a huge chaotic mess of separate issues that they went on to try to address separately. Without help to see the wider picture of interrelated problems they could not make sense of their experiences or move on.

Finally, perhaps the largest barrier to recovering by oneself appeared to be the survivors’ shame and self-blame. Feelings of not being good enough and feeling over-responsible prevented survivors from believing recovery could be real and something they deserved. Shame and self-blame also remained barriers to recovery because survivors did not address these difficulties directly when they used the strategies of ‘disengaging’, ‘making invisible experiences visible’ and ‘examining’ these experiences on their own. A possible reason for why shame or self-blame were not addressed may be that those emotions were not easily visible while survivors
were busy trying to manage multiple, complex current difficulties. Alternatively, there may have been resistance to exploring shame and vulnerability because it was too painful to face. The latter explanation is supported by evidence from a quantitative study of treatment-seeking substance users with PTSD showing that problem-focused disengagement as coping strategy was positively associated with trauma-related shame (Held et al., 2015). Yet, it appeared to be vital to explore shame and self-blame because the negative beliefs about oneself was so dominant and distressing for all participants. Unless survivors can be helped to face and address these deep seated fundamental negative emotions, they cannot regain the self-worth needed for recovery.

### 4.4.6. Self-guided vs supported self-management

In this grounded theory, doing recovery by oneself will be called *self-guided self-management*. It implies that survivors relied on their own resources to manage their past trauma and current difficulties. The subsequent sections will be concerned with *supported self-management*. This implies that survivors receive support from others to manage their current difficulties and find a way forward. It is also called *self-management* because, even when survivors receive support from others, these supportive others do not manage difficulties for the survivors on their behalf but, instead, guide them to manage life eventually more effectively by themselves. Supportive others – usually one or two significant people – included trauma-informed professionals (e.g., general practitioners, community psychiatric nurses, and psychologists), peer survivors, a friend, a family member, and neighbours. The current study identified several ways to transition from self-guided to supported self-management in this group of survivors.
4.4.7. Bridging the gap: When survivors and supportive others come together

Deciding to seek help and disclose abuse and trauma

Several factors prompted survivors to eventually seek help. Some survivors reported that they reached a ‘breaking point’ where managing the distress by themselves did not work anymore and, thus, they were unable to function in daily life. For example, participant 14 reported that when ignoring her anxiety, depression and recurring trauma memories stopped working, she broke down and could not do anything: “I had a breakdown at the end of <year>… Like, properly was unable to do anything and just … hit the floor and was taking; was given antidepressants, and things like that…. I was on the bus one day, and I just started crying. And I couldn’t stop crying. And thought I better go to the doctor.”

Similarly, participant 12 reported suddenly not being able to move one day. This crisis prompted them to seek help – most often from their general practitioner. Such ‘feelings of losing control’ and ‘being at the end of the rope’ have also been reported in a study on trauma survivors’ recovery by Stige et al. (2013). They suggested that the survivor’s body was taking over with “exhaustion and intrusive physical symptoms”, that survivors did ‘not understand what is happening’, that self-managing strategies were no longer effective, and that distress increased over ‘not knowing how to regain control’ (Stige et al., 2013, p. 7).

While this ‘breaking point’ was often unplanned and out of survivors’ control, two intentional aspects were also observed. Firstly, some participants realised that their symptoms and behaviours (such as anxiety, isolation, and excess alcohol consumption) were abnormal and distressing or harmful. This signalled a change: Previously, participants believed that their anxiety, flashbacks, revictimisation and other daily difficulties were simply part of normal life and – although struggling with these – they managed them through ‘disengagement’. For instance, participant
was “dissociating. But not knowing that this is what I was doing.” Participant 14 described “I didn’t know there was anything wrong. I just thought that’s how everybody lived. Sort of, terrified.” However, at this point then a crucial shift occurred whereby trauma survivors identified their experiences as abnormal. For example, while participant 13 avoided her own home to minimise anxiety, she came to understand that “this isn’t normal” and that she “cannot go on like this”. She went to her general practitioner for help. Similarly, participant 07 concluded – when reaching a round birthday – that she did not wish to drink alcohol in such amounts until the end of her life. She also sought help. Not every participant reported gaining this awareness of a crisis point before disclosure; some only realised this after disclosure and when receiving treatment (e.g., participant 05).

Secondly, survivors found themselves in an ‘either-or’ or ‘now-or-never’ moment where they could not continue as they had been trying unsuccessfully to do and were confronted with two polarised options: (1) taking action through an alternative but uncertain road right now, or (2) submitting to defeat, giving up any possibility of ever changing their life, and continuing a miserable existence with anxiety, flashbacks, and abuse where suicide might become a viable option. For example, participant 11 decided to “sort my life out”, remove herself from an abusive environment and get help: “Boom inside. I would sink or swim right now.” Correspondingly, participant 08 reported “I knew if I hadn’t started [the psycho-educational group] on that day I would never have come back [to that service].” As a result, they sought help – mostly from their general practitioner, occasionally from third sector organisations. This further indicated that survivors had made a decision of wanting to change. Stige et al. (2013) discussed that the readiness of survivors to change because life had become intolerable was important when seeking help.

These factors suggested that some form of ‘breaking point’ or crisis leading to a decision to take action was inevitable. For some participants, it appeared to be the
final motivator to seek and accept help. It suggested that self-guided self-management must collapse first for them before survivors could reach out.

**Other people reaching out actively and offering help**

It is not only trauma survivors’ initiative that built a bridge between isolated, self-reliant, self-guided self-management and supported self-management. Survivors also reported that other people took the initiative and reached out to help them. These others did so in several ways:

Firstly, survivors found it helpful when a health professional clearly acknowledged that the survivor was unwell and needed help. Participants 13, for example, reported that her general practitioner recognised that her severe anxiety and depression may have traumatic origins and referred her to trauma specialists. Participant 14’s second general practitioner not only changed the medication but also referred her to a community district nurse and, thereby, confirmed that something was not normal. And when participant 06 came to a trauma-informed service “they clearly saw that I was at crisis point and they took me in.” This reaching out by other individuals and their acknowledgement of survivors’ distress appeared to serve as antidote or supportive challenge to survivors’ ‘disengagement’ strategies: It became more difficult to tell themselves that they were not that unwell or did not need help.

Secondly, survivors valued when others took the initiative and reached out to them without being asked. For example, when participant 08 went along indifferently with a group of peers and entered the community site, a staff member reached out to her. “She could have sat anywhere ... But she came and sat beside me. ... She took my hand that day. ... She didn’t literally take my hand. ... But, you know, I felt she connected with me.” As a result, participant 08 returned to this service for ongoing support. It was not only health or support service professionals that were getting actively involved. Participant 04, 09 and 14, for example, reported that a friend or neighbour reached out to them. In one case, the friend kept in touch for several years by text...
messaging even though participant 14 did not reply, and isolated herself. This contact was a lifeline for her to reconnect with when this survivor was ready. In another case, an older woman in the neighbourhood reached out to participant 09 and offered to go shopping for her or invited her for a cup of tea. Again, this was a lifeline for this participant to social contact and support.

Thirdly, survivors appreciated it when professionals, friends, or neighbours offered to be available to them by phone for support, during opening hours without an appointment, or for a cup of tea and a chat. This provided a ‘safety net’ for survivors – even if they did not always use it. Simply knowing that someone was there if they needed them provided continuity and stability. It also offered choice. Where previously survivors relied solely on themselves to handle difficulties, now they could choose to manage these difficulties alone or request help from specific people they trusted.

**Barriers to help-seeking and help-giving**

This shows that initial help-seeking did not only originate from the survivor but also depended on support being available and being offered when needed. The initial help-seeking and help-giving process was not always straightforward. Both, survivors and supportive others, could disrupted this process. Trauma survivors, for instance, ignored or actively avoided others’ attempts to reach out. Their negative experiences with people generally might have provided a reason for rejecting help; keeping to themselves was a way to stay safe. Participant 13, for example, refused to take a phone number that a peer survivor offered to her because she did not trust non-professionals. An alternative explanation might have been that survivors felt too embarrassed or ashamed, or feared becoming too emotional. Participant 12 could not disclose domestic violence to the general practitioner, and instead only disclosed physical injuries resulting from the abuse: “I had been up to the surgery on a few occasions, sort of, in the past and not wanting to say because I had; ((speaking more quietly: )) my fingers had been broken and there’s been quite (a few) sort of
things, like, rips and, you know, a lot of rape and, you know, there had been a lot of things. But I had never disclosed why. I just would go up to get checked and say ‘Look’, you know, ‘I’ve done something with my fingers.’” Participant 08 reported that it “went over my head” when health care staff told her of their concerns after her suicide attempt. Some trauma survivors also persisted in ‘having to help yourself’ despite seeking and being offered help. Self-reliance continued to dominate their thinking and behaviours. While ‘helping yourself’ may be demonstrated more positively as wanting and seeking help, it may also be manifested more negatively where survivors continued to try fixing their problems without reaching out.

Similarly, other people disrupted this help-seeking and help-giving process. For example, participant 05 remembered that previous health professionals had failed to identify her trauma: “Nobody has ever said to me, like, you could be suffering from the effects from trauma. You know. The emotional numbness stuff, the no feeling connected with people, the flashbacks, the nightmares I was suffering from. And I had told psychiatrists. I had told doctors. And nobody had ever mentioned it [trauma] to me.” Other participants reported being given addiction treatment, or medication for anxiety and depression, but their history of abuse and trauma was only picked up by health professionals months or years later. Especially where health professionals relied on giving medication only, one survivor (participant 14) expressed frustration over not knowing what else she could do except to wait for the medication to take effect; another survivor (participant 01) turned down the medication offered by her general practitioner (GP) and sought help in the third sector instead:

“And there was nobody … telling me there was anything else to do. Say, the GP just said ‘Just go home and you’ll get better.’ And so I’m waiting to get better. You know. I’m waiting for these magic pills to suddenly take all that away. And it didn’t happen. Like, I say I kept saying ‘Well, it will be this time.’ Cause she [the GP] kept saying to me, you know what I mean, ‘I think you’ll be fine in six months.’ Or ‘you’ll probably be fine in a year.’ And it wasn’t getting fine. ((short laugh)) And it wasn’t getting any better.” (Participant 14)
It was not just the more recent disruptions to initial help-seeking by others that affected survivors. Help-seeking had previously been disrupted for some survivors in childhood when they were not believed if they disclosed abuse, or felt misunderstood or ignored. These experiences have made it difficult for them to seek help later as adults. Evidence of negative effects of unhelpful or absent responses to trauma survivors seeking help with abuse has been discussed by Charuvastra and Cloitre (2008), Chouliara et al. (2014), Dorahy et al., (2009) and Markowitz et al. (2009). Barriers to help-seeking did not only occur on the small scale where individual others interfered, but also on a larger scale where society and the media did not talk about abuse and trauma. For instance, participant 12 reflected:

“*In my era when it happened to me, nobody talked about it. You would never tell anybody that that was going on behind your front door. You wouldn’t; that wouldn’t; that was just, you know. That was accepted. You know. You just went up about your daily business and took the punch or the kick or whatever was going on. That; you wouldn’t go and tell your friend or anything. … But now, in this day and age, it’s talked about. It’s in all the papers. It’s on the television.*” (Participant 12)

This analysis has shown that the space where help-seekers and help-givers meet is fragile. Trauma survivors are at a breaking point when their usual strategies are not working anymore; they realise their symptoms are not as normal as they had thought; they want help; and it is either now or never. Yet, they are hesitant because of negative past experiences, feelings of shame and fear, years-long habit of avoidance, or being blind to help that is offered. It was crucial that health professionals, peers, friends or neighbours confirmed to survivors that they did need help, that these supportive others were actively involved and took the initiative in offering support, and that they then attempted to be available on an ongoing basis. And yet, people who could help failed to respond sometimes when they offered limited options, when individuals did not believe survivors who
disclosed abuse, or where large social groups ignore abuse and trauma as a broader cultural response.

Figure 12 shows the addition of help-seeking and help-giving in the social reconstruction model of trauma recovery:

![Figure 12. Trauma recovery model with the addition of help-seeking and help-giving](image)

4.4.8. **Relationship between supportive others and ‘making invisible experiences visible’**

Initially, as previously described, the survivors used writing, listening to music, and taking pictures as a way to make their invisible internal experiences visible on their own – to ‘get it out’ – because it helped release physiological distress and increased
awareness of previously unrecognised experiences. Now, survivors moved on to develop externalising strategies with supportive others.

Talking and listening to supportive others about trauma-related material was important. Besides releasing tension and bringing awareness, ‘making experiences visible’ collectively had additional positive outcomes. For example, talking things through with others elicited support. That is, survivors received comfort from others who acknowledged their negative feelings and the sources of these feelings (e.g., abuse, trauma, day-to-day difficulties). Also, supportive others provided alternative explanations of survivors’ ongoing difficulties than those narratives that survivors had come up with on their own. It made available another source of help that was not available previously. For example, participant 04 learned from a community psychiatric nurse visit that the ‘army in her head’ were flashbacks and may have been linked to a traumatic experience in the past. Some participants found it helpful to be given a diagnosis of, for example, PTSD. They reported that this official label indicated to them that someone else understood and could explain and help with their experiences. The label also allowed them to find out more about trauma – to ‘examine’ it. For other participants, a diagnosis caused additional distress: “when I got diagnosed with post-traumatic stress, or whatever it’s called, trauma, whatever, I just let go of everything. I didnae care. I didnae want to be alive” (Participant 01). Listening to and identifying with peer survivors had the additional benefit that survivors’ belief of ‘I am alone in this’ was challenged.

In terms of supported self-management, particularly favourable factors included being encouraged to talk about day-to-day difficulties and trauma-related material, and being listened to without judgement. These conditions provided safety as well as a breathing space for the survivors to be calm and slow down, and from which hidden or suppressed experiences could be explored. Making these difficult experiences visible with the support of others bears similarities to attachment theory (Bowlby, 1969, 1982) whereby the attuned adult provides comfort and a safe haven
to the distressed child. Once soothed, the child returns to exploring the world. With regards to trauma survivors, supportive others provided this safe haven to the adult survivor and, once reassured, the survivor continued their life but could also return to the safe haven when distress arose again. What made supportive others effective was that they were able to tune in to and acknowledge survivors’ emotional distress and, based on their experience, explain unmanageable situations to survivors. These people could help contain the survivors’ distress and make it more tolerable as a route to moving on from it.

‘Making internal experiences visible’ and more tangible was hampered by survivors’ difficulties in explaining what had happened and not having the words to express feelings or describe their internal world in the first place. They reported feeling frustrated. To an extent, survivors relied on others to explain their distress and articulate them. However, they also criticised the fact that health professionals or people in their immediate environment could not explain things well at times. Sometimes survivors reported not having talked about their distress, trauma and abuse because they were discouraged or ignored by others. One survivor reported that identifying with peer survivors in support groups felt depressing. When it was too difficult to make distress visible in conversation with others, survivors reverted back to solitary coping strategies, and particularly their habitual ‘disengagement’.

4.4.9. Relationship between supportive others and ‘examining one’s life in relation to abuse and trauma’

Together with supportive others, trauma survivors developed their strategy to look at and ‘examine’ their life affected by abuse and trauma. Supportive others helped trauma survivors to question, compare, confront, connect, or test out situations that they could not examine on their own. For example, participant 13, who was asked in group therapy how anxiety felt in one’s body, had not considered asking this
question by herself before. Only when being asked about this did she connect feeling anxious with specific sensations in her body. This appeared important to her, perhaps, because it redirected attention from anxious thoughts and negative self-talk to physiological responses and, thus, alternative ways of understanding and managing anxiety could be explored.

As previously discussed, ‘examining one’s life in relation to abuse and trauma’ could also be challenging to survivors at times and resulted in further distress. Supportive others provided a safe environment where this distress was acknowledged and explained. However, being questioned or confronted by supportive others was also reported as challenging at times, and survivors resisted. For example, participant 05 stated that she did not believe it at first when a professional suggested her day-to-day difficulties may be a result of trauma: “I thought she had it wrong. I blamed the emotional stuff, like, no being able to feel on addiction. … But then I went away and I read, like, stuff on post-traumatic stress.”

Findings related to both ‘making experiences visible’ and ‘examining one’s life in relation to abuse and trauma’ suggested that supportive others provided an antidote to problems that arose from self-guided self-management: Firstly, supportive others challenged survivors’ repetitive cycle of negative beliefs about themselves by providing alternative explanations for these beliefs, by acknowledging survivors’ experience, and by being responsive towards them which affirmed survivors as being valued. Secondly, supportive others helped survivors to regulate and reduce the emotional pain that they had previously avoided. Supportive others did this by validating survivors’ emotional experiences, by explaining why these feelings might have arisen, and by modelling effective strategies for managing these feelings. Thirdly, supportive others were actively involved in preventing the survivor from isolating themselves, while at the same time modelling successful interpersonal skills in their interaction with the survivor, or explaining interpersonal dynamics. Thus, increasingly collaborative work with other people reduced dominant ‘disengagement’
strategies, limited distress that was previously unmanageable when ‘making experiences visible’, preventing survivors from ‘examining’ their experiences by themselves, and finally helped them to focus their attention on developing a few long-term effective coping strategies. Consequently, survivors gained skills and control and appeared to become increasingly able to address their difficulties. Similar observations have been made in other studies. For instance, Anderson et al. (2012, p. 1291) interviewed women who experienced domestic violence and found that “recovery and growth could not have occurred in isolation”. In their study, validation and the resources offered by supportive others relieved the pressures of coping alone, and enabled those survivors to make changes.

Figure 13 shows the largely enabling process of having supportive others to help with ‘making invisible experiences visible’ and ‘examining’ feelings, relationships, trauma and self.
4.4.10. Supported self-management enables reconstruction of reality

The back and forth journey between ‘making invisible experiences visible’ and ‘examining one’s life in relation to abuse and trauma’, and enabled by supportive others, gradually reconstructed survivors’ perceptions of abuse and trauma, of choice and control, of themselves, and of their responsibility (Figure 14). Social support was vital in this reconstruction process. Little ‘reconstructing’ occurred during self-guided self-management. Rather, various beliefs constructed during the abusive environment appeared to reaffirm themselves. For example, efforts to address trauma-related day-to-day difficulties by ‘making them visible’ and ‘examining’ them were of questionable value because they brought further distress from the newly discovered material. Negative beliefs about oneself, such as ‘I am not good enough’ or ‘I am incapable’, prevented survivors from making changes and kept them in a cycle of low self-worth. By contrast, reframing the various aspects of a survivor’s life was made possible when supportive others provided alternative and plausible perspectives to the person’s current beliefs. They provided new frames of references for what is normal, what is effective or what is possible. They also provided a secure base. The next paragraph describes what this social reconstruction looked like for this group of survivors with regard to how they reconstructed reality about (a) abuse and trauma, (b) choice and control, (c) themselves as person, and (d) responsibility for abuse and recovery.

(a) In interaction with supportive others, survivors uncovered the range of day-to-day difficulties, collaboratively found explanations for them and, gradually, came to understand their difficulties, not as unmanageable, disconnected, never-ceasing problems, but as normal responses to traumatic events for which others have found solutions. Similarly, professionals, peer survivors and others played an important role in helping survivors reframe that day-to-day difficulties were responses to trauma and abuse, and that
their past maltreatment by others were not acceptable or deserved but, instead, unacceptable and abusive.

(b) With regards to reconstructing choice and control, alternative resources opened up when survivors gained increasing insight into their feelings, thoughts, behaviours, interactions and negative beliefs with the help of others. New resources allowed survivors more choice and control in how to manage their own difficulties, as well as to make better and more informed choices because supportive others provided guidance on effective and ineffective coping strategies.

(c) Survivors’ self-worth increased when supportive others were ‘being there’ for them. ‘Being there for me’ was a phrase frequently mentioned and involved being listened to, having things explained, being comforted, being available, or being guided. This active reaching out to trauma survivors communicated to them that they are worthwhile people. Where an abusive environment made them feel inadequate, the supportive environment made them feel valued. Social support reintegrated the excluded survivor into the community.

(d) A new sense of responsibility was constructed, when the blame for former mistreatment was reassigned to the person carrying out the abuse and when responsibility for managing day-to-day difficulties was shared with supportive others through their active involvement in the survivor’s recovery. Attributing blame to perpetrators, bystanders or unsupportive professionals was more prominent among survivors from the community site than from the clinical site. This could perhaps have been due to a greater tendency towards the construction of a shared social view about abuse and trauma amongst the members of this peer group survivors with the result that they developed some form of ‘in-group’ solidarity which set
them against an ‘out-group’ of abusive and neglectful others. Other studies have provided evidence that externalising blame can increase resilience in survivors of childhood sexual abuse (Domhardt et al., 2015).

Reconstructing reality was important because it allowed survivors to leave their abusive past behind. It offered new resources to manage distress, solve practical problems, and build healthy relationships. A positive belief about oneself provided a base for a survivor to make effective changes and a shield against potential future mistreatment. Thus, reconstructing reality gradually allowed survivors to recover, move on and participate more fully in life.

Figure 14. Supported self-management enables reconstruction of reality
4.4.11. Recovery: Having a life

What did adults, who experienced ongoing abuse, perceive as ‘recovery’? Some participants used the term ‘recovery’ when talking about trauma in a similar way as they used ‘recovery’ when talking about addiction; or they compared it to recovering from hospital operations:

“I try and keep them [recovery from addiction and trauma] together in terms of; cause if I separate them it becomes too difficult. If I try and, if I try say, like, my numbness is only because of trauma then I forget I’m an addict.” (Participant 05)

“It’s recovery. … If you go through an operation in hospital you recover from it, don’t you?” (Participant 07)

With this understanding, the aim appears to focus on reducing trauma-related difficulties (e.g., flashbacks, dissociations, revictimisation) and on staying sober and clean (e.g., participant 05, 07). This is consistent with the treatment literature that focuses on symptom reduction (e.g., Burton et al., 2015). However, alternatively, some have argued that this focus is limited and, instead, trauma survivors need to gain emotional, interpersonal and other life skills, too, as well as become integrated into community (Burton et al., 2015; Herman, 1992). This was reflected in the current sample where participants talked about ‘having a life’ (e.g., participant 04, 07). ‘Having a life’ involved being able to participate in life, that is, to continue higher education, to return to work, to be able to raise children well, to maintain a loving intimate relationship, to manage finances, or to be able to travel and look after oneself:

“For me, it means … having relationships with people and working. Being able to look after myself with people.” (Participant 04)
“Well, I should be able to go out! And go on the bus ((short laugh)). And jump on the bus, go up the stairs. Should be able to walk on the pavement. I should be able to go into the pub. I should be able to go for meals. I should be able to go; I should be able to go shopping. Well, I can go shopping. But I should be able to go and try things on. I should, you know, I should be able to have money. I should be able to do things, going on nice holidays. I should be doing what everybody else is doing!” (Participant 12)

This sense of getting back to a ‘normal routine’ has also been emphasised by Burton et al. (2015) when they suggested that recovery involves both resuming daily activities and taking on those tasks that survivors had previously disengaged from. Feeling stronger and valued as a person reflected enhanced self-worth and was repeatedly reported as important factor for ‘having a life’. Occasionally, survivors reported feeling grateful and being able to have fun (e.g., participant 04 and 08).

Yet, it was not always straightforward what ‘recovery’ or ‘having a life’ looked like to survivors. For example, participant 15 reported having gained most of those aspects that make up ‘having a life’ but did not feel satisfied because she had continued difficulty coming to terms with her residual distress in ways she could accept:

“Obviously I’m doing well. But I just don’t feel it. And that’s upsetting. Because I’d always thought when I was younger, if I get this, this, this and this, I feel so much better. And like you said, I’ve got four out of five [goals] and I still don’t feel any better. And I think that, kind of, scares me in a way to try and do any more. Cause I’m like; every time I achieve something that I thought was gonna make me feel better and it doesn’t, then it’s just like a let-down. You know. Rather than being happy that I’ve achieved something, I’m disappointed because I don’t feel better.” (Participant 15)

Other participants reported that it was not so much about ‘recovering’ for them but about ‘surviving life’, ‘keeping going’, ‘moving forward’, and ‘living with’ what had happened (e.g., participant 06, 11, and 13). Participant 11, for instance, said “I learned
that it’s not about getting better. It’s just about living with.” This was not perceived as ‘living life’ properly. Rather, this person continued to feel affected by abuse and trauma, and continued to find it difficult to manage life. However, some also talked about not giving in to day-to-day difficulties. Partial recovery was also reported: “So although I think I recovered from the traumatic event, that probably relate[s] to this, like, I haven’t really recovered from, like, the impact of it. So, like, the emotional side” (participant 05).

While participants occasionally spoke of aiming to get their life back, there was a strong sense that this did not imply returning to their previous life because that life consisted of abuse and trauma. Participant 14 reported: “Before I had my breakdown. I say ‘normal’ life. But I don’t want to go back to how I felt before. I want to go back to doing all the things I did before but without the background anxiety and terror that I always had.” However, in some cases ‘having a life’ might require “building a new life from scratch” (participant 07).

Overall, this suggested that adults, who have experienced long-term trauma from abuse, need support not only to manage and reduce day-to-day difficulties but also to figure out what ‘having a life’ looks like to them.

4.4.12. Oscillating effects

The literature review provided evidence that ongoing abuse can result in long-term traumatic stress. Equally there is evidence that it takes considerable time before survivors seek and receive help and can claim to have built a new life (Allnock & Miller, 2013; Kogan, 2004; Smith et al., 2000). Reconstructing one’s life after abuse and trauma is a long-term process. A major factor was that survivors oscillated so much between different strategies and components. For example, some survivors reported that they received valuable support from a service but then became
overwhelmed by this support or by what they learned about trauma and abuse (e.g., participant 05 and 08). Consequently, they returned to self-guided self-management and ‘disengagement’ strategies, before returning to the service several months later.

“I came away from the <service> for a while as well. Cause I felt threatened. Even in the place I feel the safest I felt very threatened. The only way I can describe it, I was just back to being this wee lassie that was very scared, very isolated, very ‘Oah. Just what is going on?!’ So I even came away from the <service> that, as I say, I feel the most safest.” (Participant 05)

Similarly, some survivors accessed and completed a trauma treatment programme, but entered or continued an intimate relationship that showed signs of abuse and neglect. This relationship might sabotage efforts of supportive others and the individual survivor to reconstruct their reality. Figure 15 illustrates this oscillating effect and Figure 16 incorporates all the components into the complete model.

![Figure 15. Oscillating between abusive/neglectful environments, self-guided self-management, supported self-management, and recovery](image-url)

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Figure 16. Social reconstruction model of trauma recovery

Chapter 4: Study results and a theory of trauma recovery
4.4.13. Social reconstruction of traumatic experiences at institutional, sociological, and cultural levels

It is crucial to understand that survivors faced barriers that were difficult to overcome by themselves and, thus, receiving adequate support from people around them was vital. While the model emerging from this study focuses on individual, psychological trauma and recovery (micro level), it could also be extended to encompass institutional, sociological and cultural levels (macro level).

In other words, the theory proposed here is that people in the trauma survivor’s immediate environment could facilitate the (re)construction of survivors’ negative or positive belief. That is, the abuser and bystanders constructed maltreatment as normal and acceptable, constructed the environment as uncontrollable, and constructed the victim as worthless and responsible. By contrast, health professionals, peer survivors, friends, family and neighbours helped survivors reconstruct seemingly ‘acceptable’ behaviour as abuse or neglect, helped reconstruct trauma effects as normal responses, and helped reconstruct a life with more choice and control, self-worth, and appropriate responsibility.

Taking this further into wider domains, the media, legal system, institutions, policies, education and wider society can also contribute to, or hinder, survivors’ recovery. For example, by neglecting issues of child abuse and domestic violence or by presenting rape victims as irresponsible, the media portrays abuse as non-existent, normal and the victim’s fault. In contrast, by releasing increasingly more news stories on childhood abuse, sexual abuse and domestic violence and by portraying it as wrong, the media might support trauma survivors to open-up and talk about their experiences. Also, by constructing a public narrative of abuse and neglect as unacceptable, the media could reframe the narrative – just like survivor and therapist reconstruct the survivor’s understanding of abuse and trauma in treatment. In this way, the media shifts responsibility for the abuse to the abuser.
and shares responsibility in survivors’ trauma recovery. Similarly, lawyers in court have the power to silence or give voice to the victim, to construct a narrative of the abuser as innocent or as guilty, and to shift and share responsibility or to hold the trauma survivor as accountable. A few participants hinted at the influence of wider society on their recovery. For instance, participant 12 talked about the difference between now and several decades ago:

“If I would be living my life over again and I knew as much as what I do now, you know, with all this media and police and da da da da da, I wouldn’t have been there [in the abusive relationship] for all that time. I would have been up and out. … But you didn’t have that option then.”

When nobody around her talked about abuse it prevented her from leaving an abusive relationship and from seeking help early. Instead, she felt abuse was both non-existent and normal, and, thus, she remained in it for many years.

Similarly, participant 11 reflected: “And now, I think, the world is fucked. Not me. I am as fucked, but the fucking world is even worse.”

At a cultural level, it appeared that these women had been socialised into accepting violence and neglect as normal from their childhood onwards, and this acceptance was reinforced by repeated traumatic events over the course of their life. This abusive environment reconstructed participants as worthless, incapable and inadequate. They became excluded from society which was evident in the way they isolated themselves and avoided people, as well as in shame and low self-worth. Interpersonal violence against women and girls may be regarded as ‘cultural trauma’. This concept has been applied by Alexander (2016) to Jewish people during the Holocaust or Korean ‘comfort women’ enslaved by imperial Japan. It implies that individuals with a shared social identity have been exposed to “a horrendous event that leaves indelible marks upon their collective consciousness, marking their
memories forever and changing their future identity in fundamental and irrevocable ways” (Alexander, 2016, p. 4). It could be argued that it applies equally to a social group of women and girls where approximately one in three and one in five, respectively, have experienced severe maltreatment in relationships or in the family. This interpersonal violence left them traumatised with their future identity permanently altered, and might even signal to them that being female means being less than human. Similar to the trauma recovery theory proposed in this study, Alexander (2016, p. 9) suggested that the inferior position (for example of Jews, or women/girls) is constructed by others, and requires “moral inversion and narrative revision” with shifted and shared responsibilities on a societal level (i.e., social reconstruction of reality).

Due to this long-term exposure to interpersonal violence, reconstructing a life after trauma is also a long-term process in which the individual undergoes a process of social inclusion and resocialisation. At various levels, society can hinder this process of reintegration, for example, by silencing survivors or constructing an incomplete account of abuse, choice and control, and responsibility. However, at every level in society the recovery process can also be facilitated, for example, by talking about abuse and trauma, by reconstructing authentic narratives, and by lifting and sharing the responsibility for abuse and trauma. Figure 17 illustrates an ecological social reconstruction model of trauma recovery.
Figure 17. Ecological social reconstruction model of trauma recovery
Chapter 5: Discussion

5.1. Summary of results

This study explored how adult survivors recovered from experiences of interpersonal trauma and, particularly, how they acquired emotion regulation and interpersonal skills. A constructivist grounded theory methodology was used to collect and analyse interview data. The findings fitted a theoretical model in which survivors reconstructed their cognitive, emotional and interpersonal experiences around abuse and trauma within a social context and through interactions with supportive others. That is, the way survivors initially thought, felt, interacted and responded after abuse and neglect was reinterpreted from a different social perspective with the help of a supportive environment. This altered perspective changed survivors’ priorities and, thus, their responses. Survivors’ experiences were socially reconstructed by them, and frequently together with supportive others, and this social reframing contributed to trauma recovery. This social reconstruction was twofold: Firstly, the content was reconstructed from abuse being perceived by individual survivors as socially acceptable but then over time it was reframed as unacceptable. Initially, they found it difficult to cope with abuse and this difficulty was perceived as socially unacceptable, but they were gradually able to reframe this response as normal reaction. Secondly, this process of reconstruction took place most effectively within the survivors’ social environment, namely supportive others. Survivors used their initially small social support network to draw on other people’s resources and used these to develop their own coping strategies. At the same time, developing these adaptive strategies meant that they could expand their support network. In addition, the findings have shown that recovery from trauma
cannot remain limited to how an individual functions or to interactions between an individual survivor and one other, such as a therapist. Recovery also requires attention to be paid to the role of different social groups, institutions, society and culture at large. As such, a social reconstruction model of trauma recovery is ecological.

The following sections will discuss these findings in light of their implications for existing theories and research, for practice, and for policies. Subsequently, this chapter will reflect on unanswered questions and study limitations before proposing future research. A concluding section will summarise the key contribution of this piece of work.

5.2. Implications for theory

5.2.1. Processes of cognitive processing

The study findings have six key implications in relation to previous theories and research. Firstly, while the model developed in this study confirmed that cognitive processing plays an important role in trauma recovery, it also suggested that there are different aspects to it. The four themes of ‘disengaging’, ‘making abuse and trauma visible’, ‘examining’ it, and eventually ‘reconstructing’ reality highlighted the centrality of cognitive coping strategies. Some of these have been studied in previous research, such as experiential avoidance, thought suppression, rumination, and (re)appraisal (Barlow et al., 2017; Ehlers & Clark, 2000; Ehring et al., 2014; Held et al., 2015; Naragon-Gainey et al., 2017). As such, recovering from trauma is a task requiring significant cognitive effort, and this finding is not new. However, by generating these four themes and discussing the processes that connect them, a framework evolved of how survivors moved forwards from avoiding trauma processing or from engaging in so-called negative cognitive appraisal toward
cognitive processing and reappraisal. The findings of this study revealed a step-by-step cognitive approach to processing and reconstructing trauma experiences: from (1) cognitive disengagement to (2) giving attention to trauma-related thoughts, to (3) examining what has been made visible and, eventually to (4) constructing a new perspective. Identifying this pathway is important because it allows identification of what stages occur within the overall cognitive process and where trauma survivors are likely to encounter difficulties and need support. In addition, the model developed during this study challenges previous understandings about cognitive trauma processing which have emphasised that a cognitive shift is brought about by the individual survivor themselves (e.g., Ehlers & Clark, 2000). Crucially, this research showed that the journey to recovery from trauma was shaped significantly by cognitive changes and processes as part of an interpersonal mechanism and development. This will be discussed in more detail later.

5.2.2. The ‘what’ of reappraisal in ‘reconstructing reality’

Secondly, the four subthemes included under ‘reconstructing reality’ explain more clearly than previous literature on ‘cognitive reappraisal’ exactly what is appraised and reappraised during a survivor’s recovery journey, namely (1) abuse experiences and traumatic sequels, (2) self-worth, (3) a sense of choice and control, and (4) shifting and sharing responsibility. Again, a crucial role was taken by supportive others in reframing these aspects.

5.2.3. ‘Adaptive’ and ‘maladaptive’ coping as context-dependent

Thirdly, where previous literature distinguished between adaptive and maladaptive coping, findings from my study revealed a more nuanced picture. That is, disengagement strategies (in particular, avoidance, suppression and escape) were
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adaptive in specific circumstances – a point that has been previously highlighted by Naragon-Gainey et al. (2017) and is in line with developmental models. For example, some survivors who were still exposed to abuse minimised harm by avoiding confrontation. Some survivors just accepted that they had no viable alternative strategies available when coping by themselves, and other survivors experienced multiple high stressors simultaneously and, by disengaging from some of these, they prioritised what to focus their energies on in order to make their situation more manageable for them. This study also identified positive forms of disengagement, such as listening to music, writing, or practicing yoga or meditation. Positive aspects of these were identified as being mindfulness-like quality (as discussed by Garland et al., 2015) which functioned to distract the person from distressing material initially, but then began to foster new awareness (‘making visible’) and re-evaluation (‘examining’). In a similar way, rumination has been considered generally as maladaptive (Ehring et al., 2014). Yet, findings in this group of trauma survivors indicated that rumination – observed as a form of ‘examining’ under self-guided self-management conditions and with a tendency to cause further distress – may be an early form of reappraisal. The problem was a lack of positive support able to intervene and help the survivors with negative and intrusive thought cycles. These examples suggest that a bi-directional understanding of specific adaptive and maladaptive strategies requires review and revision. Theories and research need to account for the different functions these key coping strategies might have in different contexts.

5.2.4. Importance of a supportive environment

Next, this study’s findings demonstrated that trauma recovery does not occur in a vacuum, and that a supportive social network after exposure to an abusive and neglectful environment is crucial. That is, for participants, supportive others had the important function of providing comfort and guidance when ‘making abuse and
trauma visible’ and when ‘examining’ it, or by offering a safe space in which to try out new coping strategies. Survivors also sought out others who validated their distressing experiences, respected them as human beings, and encouraged them, thus combatting shame and low self-esteem. For participants, supportive others functioned as a place where they could acquire a shared language that then enabled these survivors to talk about abuse, trauma, and emotional and interpersonal difficulties, and to reframe it. Survivors made use of supportive others, and themselves contributed to a shared community of experiences. Consequently, findings of this study challenge the notion that trauma recovery, emotion regulation and interpersonal skills are gained solely as a result of the efforts of an individual survivor. While people can work through trauma to some extent and be guided to do so, they are also relational so social support enhances personal effort. This study has highlighted that the proactive involvement of compassionate and supportive others can alter the trauma recovery trajectory substantially with significant positive effects. In addition, this social or community contextual factor interacted considerably with cognitive, emotional and interpersonal aspects of trauma recovery. This calls into question to what extent research, that isolates these factors, is useful because it does not take account of the complexity of trauma recovery.

A few theories of trauma recovery have considered its complexity as well as its social and contextual dimensions. Three of these will be discussed here and compared to the model generated in this study. Herman’s (1992, 2015) phase-based model included a third stage relating to community reintegration. However, this model suggested a sequential pathway, with community engagement being considered last towards the end of the recovery process. This was not supported by the findings of my study. Instead, supportive others provided validation and safety in the early stages of help-seeking while simultaneously offering survivors a gradual way back into community and social settings. Community engagement may be better if it is considered in parallel to Herman’s (1992, 2015) stage one (seeking safety) and stage two (trauma processing) because it can provide a safe haven and
continuity when trauma processing is distressing. Another theory bears some resemblance to the current study findings. Grych et al.’s (2015) Resilience Portfolio Model for interpersonal violence emphasised regulatory, interpersonal, and meaning-making strengths. These three protective factors were also features of this social support and engagement. However, Grych et al.’s (2015) model underrated the importance of social and contextual factors as well as the impact supportive others can have on survivors’ identity reconstruction. While they did elaborate on the relevance of resources (such as supportive relationships and environmental factors), their overall conclusions then ignored this aspect and presented resilience to interpersonal violence as an intrapsychic concept. A third theory – Maercker and Horn’s (2013) socio-interpersonal model of PTSD – comprised three levels: difficulties of managing social affect at the intrapsychic level, difficulties with close relationships (dyadic processes), and difficulties at the cultural and societal level. While their theory was distinctive in highlighting social factors, it did not account for survivors’ reconstruction of reality which permeated all the levels and it tended to focus on illness. By contrast, the social reconstruction model of my study emphasised the impact of socio-interpersonal factors on survivors’ reconstruction of reality, and it focused on trauma recovery.

5.2.5. Trauma concepts include a range of emotional experiences

Another factor with important implications for trauma recovery concerns the emotions typically associated with PTSD. Trauma tends to be conceptualised around the emotion of anxiety (American Psychiatric Association, 2007; Taylor, 2015). Yet, this study showed a complex interplay of emotional reactions. For instance, shame was frequently experienced by participants, and this has been explored increasingly in other research (Budden, 2009; DeCou, Cole, Lynch, Wong, & Matthews, 2017; Held et al., 2015; Kim et al., 2009; Saraiya & Lopez-Castro, 2016; Taylor, 2015). Also, anger emerged as an emotion that female survivors in my study
found difficult to manage and seemed reluctant to talk about. Social norms may dictate that being angry is not acceptable for women and, therefore, anger might be overlooked in research and practice. There is less research on feeling, expressing and coping with anger in trauma survivors, especially in female survivors. In addition, the survivors that were interviewed often reported feeling confused. While this may have been related to not understanding what was going on and might have implied a lack of cognitive coping, not understanding also seemed to be a highly emotional experience for these participants. Previous research and theoretical models have not addressed the sense of confusion trauma survivors seem to feel. The findings of this study indicate that the concept of trauma and its recovery journey needs to account for a wide range of evolving and interacting emotional experiences.

5.2.6. Behavioural coping in trauma recovery

Finally, trauma research and theories have focused on cognition and less is known about behavioural responses. While some behaviours have been identified in trauma survivors before (e.g., avoiding experiences and people, suppressing emotions, becoming hostile verbally and physically) others are less well recognised. In my study, it was not immediately obvious what survivors typically did or did not do in terms of their observable behaviours. Nonetheless, the findings did confirm that survivors responded with avoidance, suppression and escape, and occasionally hostile behaviour. In addition, they highlighted the benefits of recreational activities (e.g., taking pictures, doing yoga, and knitting). While these activities served initially as a distraction (disengaging behaviour), they then offered a gentle way of looking at (‘making visible’) and ‘examining’ and ‘reconstructing’ one’s traumatic experiences. These experiences became more manageable when viewed from a distance. As described in relation to coping strategies, these creative activities had a mindfulness-like quality, as described by Garland et al. (2015). At first, attention is
given to sensational experiences in the here and now which helps a person to detach from trauma-related experiences in the mind and then space is created that allows them to re-evaluate their experiences from a new perspective. These mindfulness-like, behavioural coping strategies are less well researched and conceptualised in trauma theories. They warrant more attention as they seemed to be acceptable and effective elements of trauma recovery in this study.

5.3. **Implications for practice**

There are several implications for practice arising from the findings of this study. This section will discuss and propose some possible options for improving interventions, screening, and prevention.

5.3.1. **Suggestions for interventions**

Regarding interventions for trauma survivors, four changes are proposed. Firstly, this study identified that supportive others were crucial in helping trauma survivors find the words to articulate and explain difficult experiences, manage negative emotions and relate to others better. In particular, having a source of ongoing, familiar support that could be accessed flexibly as the need arose was important to survivors. By contrast, formal trauma-focused treatments offered by health services tends to be time-limited to about 8-12 weeks (Bisson et al., 2007; Foa, 2009; NICE, 2005, update from 2014) and occurs in isolation from community resources. Participants in this doctoral study reported this disconnection as problematic because when distress increased between treatment sessions or after treatment ended, they lacked adequate social support. This finding also highlighted the fact that trauma recovery is a long-term process so short-term treatments alone will not suffice and a single therapeutic relationship will not deliver sustainable life changes.
Therefore, one suggestion would be to combine formal trauma-focused treatment by specialists with informal support available in the community. This may require collaboration between statutory health services and third sector agencies or supportive family, friends or neighbours of the survivor. For example, if prolonged exposure therapy or trauma-focused CBT were well coordinated with community support, then this informal support could help survivors manage distress arising from exposure to trauma material during treatment much better and drop-out rates might be reduced. Survivors would have opportunities to explore and try out the coping strategies and strategies designed to provoke supportive responses that they have acquired from formal treatment in familiar, informal settings. This not only helps them to develop their coping skills but also changes single supportive, therapeutic relationships to a much wider social circle. A multidisciplinary approach could also include well-established collaborations between key professionals in a survivor’s social network: such as the general practitioner, social worker, family therapist, and their child’s teacher. Alternatively, multidisciplinary health and care centres could offer a range of services including general practitioners, psychologists, social workers, nurses, legal aid and a job centre in one place. Service models of this kind have been proposed before by Hillis, Mercy, Amobi, and Kress (2016), and Reeves (2015), and in some places this has been put into practice (e.g., Wester Hailes Healthy Living Centre in Edinburgh). Yet, wider implementation and evaluation are necessary.

Secondly, findings of this study showed that various recreational activities fostered trauma processing in a somewhat gentler way than direct exposure to traumatic material in treatment. While further research is certainly required to explore the effectiveness of these approaches more systematically, recent studies have demonstrated their potential in trauma recovery (Banks et al., 2015; Nolan, 2016; Pascual-Leone et al., 2016). Thus, activities, such as physical exercise, creating pictures, writing, crafting, mindfulness or yoga could be more widely promoted among trauma survivors. Such interventions could be pursued individually when
no support is available or wanted as well as in groups where a sense of community and belonging can be fostered among peer survivors.

Thirdly, the findings from this study highlighted that participants had difficulties with managing anger and trusting people. While these two difficulties have been reported in previous studies (Cloitre et al., 2010; Lutz-Zois et al., 2011), interventions and evidence on their effectiveness seem to be limited. In particular, anger in women survivors does not tend to be addressed in research and practice (Maercker & Hecker, 2016). However, in this study it was clear that these women were angry and struggled to express it appropriately, with a tendency to suppress it. With regards to distrust, the participants frequently avoided people as well as sometimes entering risky relationships. This finding is supported by Lutz-Zois et al.’s (2011) theory. That is, trauma survivors may not be able to distinguish cues of trustworthiness and untrustworthiness. If concepts of trust and mistrust become meaningless, every person can be considered as untrustworthy. Therefore, anger management courses for female trauma survivors and psycho-educational courses on trust may be beneficial.

Finally, employment programmes could support survivors as they try to reintegrate into working life. It was noteworthy that women in this study wished to contribute to society, and all were educated at tertiary level. Yet, most of them reported being unemployed or, in a few cases, were only working part-time. Being unemployed and subsequently living on benefits often exacerbates a sense of stigma and not belonging so risks keeping trauma survivors in a cycle of ‘not being good enough’. An ecological model of social reconstruction following trauma suggests that responsibility for recovery of individuals affected by trauma also lies at a wider societal level. Trauma-informed re-employment strategies may be needed. Some third-sector projects have been established where survivors can volunteer or work, for example, as mentors, cooks or baristas in community cafes or service centres where they also seek and receive help (e.g., ‘Ask me’ pilot by Women’s Aid, the
Grassmarket Community Project, and the WomenZone project). These projects have the added benefit that trauma survivors can work in a trauma-informed environment where trained staff members are available to provide psychological support. Such working environments increase survivors’ employability and their sense of being valuable and valued in society. What is more, in order to reduce violence against women and children, Devries et al. (2013) and the WHO (2013) have emphasised the necessity for wider economic interventions, such as promoting women’s economic rights by providing equal access to formal, paid employment and eliminating gender inequality.

5.3.2. Suggestions for screening

Interventions can only be implemented where abuse or trauma has been identified. However, the trauma literature has repeatedly highlighted concerns about poor identification of violence against women and children, as well as subsequent trauma (Barlow et al., 2017; Reeves, 2015). Thus, screening should be improved in various areas where these people may live, study, work or seek help.

For instance, screening children and young people for abuse and trauma in primary care could be improved. Participants in this study described a trajectory going from childhood maltreatment to abuse that continued into adulthood with subsequent complex mental health problems. Early recognition, and subsequent early intervention, by health providers and other authorities may have prevented this outcome. According to the National Institute for Health and Care Excellence (NICE, 2005, update from 2014), children may not directly disclose trauma symptoms, and asking guardians may not be reliable. Thus, they advise professionals to inquire directly about PTSD symptoms. This may not be routine perhaps due to a lack of training in this area or other pressures of time and demand. In fact, Flynn et al. (2015) reviewed studies showing that educating primary care providers in trauma...
screening and trauma recognition substantially increased the rate of identifying trauma. Some of these studies have also indicated that it is important to supplement this training with information on adequate interventions and available community resources. Similarly, children displaying difficult behaviour or low performance in school could be screened for trauma and exposure to violence. This would identify additional cases that may not present with health problems to primary care. There is well-established evidence linking childhood maltreatment with poorer educational and behavioural performance (Fry et al., 2017; Romano et al., 2015). Again, training and adequate resources at school level are required.

Equally, screening for past child abuse experiences in adults and for domestic violence or intimate partner violence in adulthood does not appear to be routine. Reeves (2015), for example, discussed research demonstrating that less than 20% of female survivors of childhood sexual abuse were asked about abuse by health care professionals, but that 96.5% of female survivors would welcome being asked routinely. Findings of the current doctoral study also confirmed that participants reported frustration about not having been asked about experiences of abuse in childhood or adulthood, and about health care professionals not having recognised trauma symptoms earlier. Thus, proactive and routine inquiry by health practitioners may increase recognition. Indeed, a review by O’Doherty et al. (2014) has reported evidence that screening did increase recognition of intimate partner violence. However, improved screening did not reduce intimate partner violence, and this may have been due to inadequate or no referrals being made to services after identification. Assessing a history of abuse may be valuable, particularly in patients presenting with mental health problems where a high prevalence of domestic violence has been reported (Howard et al., 2010) and in expectant parents where early detection of a parent’s exposure to childhood maltreatment or intimate partner violence and early intervention may prevent transgenerational trauma. It is important that not only intimate partner violence in adulthood is detected, but also childhood maltreatment in adulthood. Findings of this study suggested that
addressing only intimate partner violence may not reduce the suffering and skills deficits resulting from childhood trauma. A study by Gobin and Freyd (2014) strengthens the view that both trauma from intimate partner violence and childhood maltreatment, need to be addressed. Their study reported an association of both childhood maltreatment and intimate partner violence with PTSD symptoms. The association between childhood maltreatment and PTSD was not influenced by the presence or absence of intimate partner violence, suggesting that it is crucial to address childhood maltreatment as well as intimate partner violence in order to reduce trauma symptoms. Therefore, screening adult patients for a history of interpersonal traumatic events as well as training in screening and linking screening with adequate provision of support is imperative.

5.3.3. Suggestions for prevention

Human and economic costs resulting from abuse and trauma could be much reduced through effective prevention strategies. An ecological approach to social reconstruction of interpersonal trauma and recovery implies that there is a need to challenge societal acceptance of violence against women and children at different levels, and to address popular ignorance of the impact of that violence on people’s long-term health and well-being.

For example, sex education in schools could be extended to include relationship education. Learning interpersonal strategies and how to talk about relating well to others early in life may not only encourage young people to disclose harmful relationships, but may also prevent them from later exposure to intimate partner violence. The well-established evidence of childhood maltreatment and subsequent revictimisation in adulthood would support this approach (e.g., Berthelot et al., 2014; Gobin & Freyd, 2014; Lang et al., 2004). Findings from my study are consistent with this evidence. It was clear that many of the women had been socialised into
accepting violence in relationships as being normal or acceptable. Thus, early relationship education may challenge an inappropriate tolerance of interpersonal violence. Examples of prevention campaigns include the NSPCC’s “Speak out Stay safe” programme for primary schools (NSPCC, 2017a) and “The Underwear Rule” for schools and teachers (NSPCC, 2017b). Similarly, children and young people may benefit from health education in school that helps them to tackle stigma and learn about self-care or mental health care support early on.

In addition, parenting support programmes could be offered more widely. Most participants in this study had child care responsibilities and expressed concerns that their mental health difficulties resulting from trauma may have impacted on their parenting abilities and their children’s well-being. Access to parenting support may give parents, particularly those with a history of exposure to violence, more confidence and may prevent or reduce the risk of transgenerational trauma. Many parenting support programmes have been developed some focusing on prevention and others on reduction of child maltreatment (Euser, Alink, Stoltenborgh, Bakermans-Kranenburg, & van Ijzendoorn, 2015). However, a systematic review by Euser et al. (2015) showed that most programmes only reduced, but did not prevent, child maltreatment. Thus, further research and improvement in this area are necessary.

Furthermore, community based programmes could strengthen capacity in local neighbourhoods with the aim of preventing child maltreatment and intimate partner violence. Van Dijken et al. (2015, p. 156) conducted a review of community-based interventions to see if they had the potential to increased social capital (defined as: “collective efficacy, shared responsibility and informal social support”) and whether that would prevent child maltreatment. However, only a few Western studies could be found that met their eligibility criteria and other identified programmes had not been evaluated systematically. Mannell and Dadswell (2017) evaluated a community mobilisation programme designed to prevent intimate
partner violence in low-income settings. Their thematic analysis recommended that community prevention might benefit from: understanding what constitutes intimate partner violence, providing resources to support women economically when they leave an abusive partner, breaking the silence around intimate partner violence, engaging policy makers and government authorities, and challenging discriminatory policies and legal structures. Overall, there are difficulties in evaluating the effectiveness and long-term impact of community interventions due to multiple factors (Bourey, Williams, Bernstein, & Stephenson, 2015; DeGue et al., 2012; Mannell & Dadswell, 2017; van Dijken et al., 2015).

Social reconstruction of abuse and trauma demands that responsibility for prevention is shared because abuse and trauma is a social problem, requiring actions by individuals as well as on wider community and societal levels. It requires a social solution, and multilevel and multisector engagement.

5.4. Implications for policy

Prevention, screening and intervention require organisational and national guidelines that help reconstruct reality for trauma survivors and ensure that responsibility is shared widely as part of a collective effort to promote trauma reduction and recovery. Due to the complex needs of trauma survivors and the predominant intrapsychic focus of current efforts to address interpersonal trauma, a concerted effort by multiple agencies and community organisations is crucial. Policy changes at different levels are needed, starting with recognition of the extent and importance of this problem.

Firstly, health care services could develop strategies to train staff in identifying child maltreatment, intimate partner violence, and psychological trauma. In the UK, general practitioners would be an obvious group where mandatory training would
be beneficial because they act as a gatekeeper for other more specialised services and, thus, tend to be the first point of contact for many people. However, currently NICE (2014) only recommends that general practitioners receive training on screening and referral pathways for domestic abuse instead of mandating it. Participants in this study, in common with others, reported that they were not asked directly about their exposure to violence and possible trauma sequelae in primary care leading to poor identification. As a result, the underlying trauma diagnosis and adequate support was delayed. Strategies at a wider health services level could promote trauma-informed care across agencies and providers. For example, Reeves (2015) suggested that trauma-informed care could involve dentists, sexual health services and emergency services. Other organisational strategies in the health care sector could promote collaborative working among multiple agencies within the health care sector, with social, educational and justice sectors, as well as with the third sector, and with families and neighbourhoods (Hillis et al., 2016). While some collaborative links have begun to emerge, a wider effort supported by policies might be needed.

Secondly, third sector organisations could develop community-focused strategies that help prevent or minimise interpersonal violence and provide resources to help people respond to interpersonal violence and subsequent trauma in local neighbourhoods. While some programmes exist (Mannell & Dadswell, 2017; van Dijken et al., 2015), collecting empirical evidence of their effectiveness is needed in order to secure much needed support from funding bodies.

Thirdly, at a governmental level, policies could promote multisector collaborations by providing adequate funding and other resources to, for example, health care services, social care services, and third sector services. In addition, some have proposed further reforms of family law that discriminate against women and policies that would actively strengthen women's economic and legal rights and do
more to address gender inequalities as a way of addressing issues related to interpersonal violence and trauma (Devries et al., 2013; WHO, 2013).

Finally, it is also important that such policies are actually implemented on the ground in order to effect change. Recent reports by the KidsRights Foundation (2016, 2017) have shown that this is not the case in UK child protection. Their reports found that the UK has exceptional child protection policies warranting 11th place (of 165 assessed countries) on the KidsRights Index in 2016, but because policy implementation was deemed inadequate, the UK was downgraded to 156th place in 2017. Research may be needed to establish whether this might be the case with other policies intended to support trauma survivors.

5.5. **Study limitations and reflections**

A number of study limitations have been identified. Four of these concern the chosen sample. Firstly, this study was restricted by how interpersonal trauma was defined. For my study, it included not only physical and sexual abuse but also emotional abuse, emotional and physical neglect in childhood and intimate partner violence in adulthood. As definitions vary across research studies in the field of interpersonal trauma, findings from this study may not be directly comparable with other studies. However, this is a general limitation of research in this area rather than a limitation specific to this study. What is more, because findings about the recovery process were generated from interviews with people who had experienced a range of forms of trauma, the developed model does not differentiate specific aspects unique to each trauma type. Findings from this study emerged from a sample of women who predominantly experienced both childhood abuse and intimate partner violence and, thus, should be interpreted accordingly. Related to this problem of definition is that gatekeepers at both research sites approached potential participants according to their own definition of interpersonal trauma.
While inclusion criteria for interpersonal trauma were explained to support staff, their screening for suitable participants may have differed from the researcher’s definition.

Secondly, this study only investigated a female population so the outcomes may not be transferable to the wider population of trauma survivors. According to Blain et al. (2010), studying only female survivors is common in the field of interpersonal trauma. Therefore, the focus on a female population in this study was justifiable given that women are exposed to considerably more interpersonal trauma than men and are more likely than men to develop PTSD (Kessler et al., 1995). Understanding the emotional and interpersonal factors of trauma recovery among women is the priority. Yet, I did recruit and interview a singular case of an individual who had undergone gender reassignment from male to female which revealed some unique and important differences that could be attributed to gender roles. The participant had been a boy at the time of the abuse and a man when confronting the abuser. His/her story was distinctive in that he/she reported child maltreatment to the police as adult, pursued self-justice which lifted long standing guilt and shame, reconstructed his/her identity through changing gender, and did not report seeking psychological support specific to his/her trauma. The narrative was similar in some aspects to other female participants in that he/she reported an addiction problem, escaped from the family environment in which the abuse had occurred, and found a sense of strength and belonging in a same-sex environment. This was an isolated and very distinctive case in an otherwise female sample so it is important to explore how trauma recovery from interpersonal violence is experienced as being qualitatively different or similar for men and women in future research.

Thirdly, another limitations to consider is that the sample was confined to a specific group of women receiving health and support and who came from a single, semi-urban community in south east Scotland. This might have resulted in responses unique to these populations and might lack transferability to other groups such as
people from other demographics, ethnic or cultural groups. However, drawing participants from at least two different settings provided an indication as to whether recovery processes were similar or different. Future studies could expand research to other populations.

Fourthly, this study included trauma survivors who had previously disclosed their traumatic life experiences and sought help by the time of recruitment and data collection. Thus, the findings of this study do not capture the narratives of trauma survivors who have not disclosed interpersonal trauma, who now consider themselves to have recovered and therefore have not recently accessed services, who feel they have recovered but have never sought help, who sought help elsewhere (e.g., online or self-help books only), or who recovered relatively quickly without developing long-term mental health difficulties. These inaccessible groups may differ in some ways from the convenience sample of this study. Therefore, the model may be limited to explaining trauma recovery of survivors who have disclosed interpersonal trauma and would tend to seek help from statutory and third sector services. Future research might look at ways of accessing these more ‘hidden’ groups of survivors, perhaps via social media, to explore whether the current model generalises to these other groups of trauma survivors or needs to be adapted.

Other limitations concern the analysis. For example, during coding and early analysis, a concern arose that the use of action words in grounded theory may have emphasised the actions of trauma survivors while overlooking the contribution of external factors. This point has been raised before by Rich (2012). As a result, the emerged grounded theory may attribute a disproportionate amount of responsibility to trauma survivors and, thus, would only strengthen the intrapsychic focus that has been emphasised in trauma research before. However, this does not seem to have been the case in my study where the model that was generated clearly highlighted differences in recovery based on social circumstances.
(that is, self-guided vs supported self-management), and emphasises that the social environment plays a significant role. Social factors could contribute to exacerbating and maintaining trauma (abusive or neglectful others), or facilitate recovery, help people regulate distressing emotions, and foster interpersonal skills (supportive others). A reason for this may be that I did not only code for what participants were doing, but also for the setting they were acting in.

In addition, the process of line-by-line coding fragmented the text to such an extent that the sequence of events as they unfolded in participants’ life to make up a trauma recovery journey appeared to be lost. While the findings of this study indicated broad developments from self-guided toward supported self-management, and from an initial tendency to ‘disengage’ towards gradually ‘making trauma and abuse visible’, ‘examining’ it and eventually ‘reconstructing reality’, there may be aspects to this journey that might have been overlooked because of fragmenting the narrative. The data could be reanalysed in terms of the unfolding timeline of each participant’s journey to identify evolving patterns and transitions within cases and across cases at key time points. This type of longitudinal narrative-based qualitative methodology would pull the more fragmented information together and might well reveal further insights into trauma recovery. It is well-established in health services research with people experiencing complex, emotionally charged illness journeys such as in palliative care (Murray et al., 2009).

Finally, there is a concern that the model developed in this study may not only explain trauma recovery but also partially addiction recovery. This concern arose when community participants frequently talked of recovery from addiction as well as from trauma simultaneously, and it was difficult at times to determine when coping strategies referred to dealing only with trauma or with addiction as well. Participant 05 also highlighted that recovery from addiction and trauma could not be separated for her. As a result, coding was not strictly limited to trauma-related talk but also to talk about addiction recovery where a link to trauma was indicated.
by participants. The same may be true for co-occurring experiences of trauma with depression, suicidality and other mental health difficulties that have been associated with interpersonal trauma before (e.g., Briere et al., 2016; Jonas et al., 2011; Martin et al., 2016; Resick et al., 2012; WHO, 2013; Zucker et al., 2006). Participants’ accounts of overcoming these additional difficulties were included in this analysis because of the link to overcoming trauma. The subsequent trauma recovery model may have been influenced by this complexity. On the other hand, this potentially confounding factor may be regarded as one of the model’s strengths because, by taking co-occurring health difficulties into account during analysis, it reflected the realities of recovering from complex trauma after interpersonal violence.

Last but not least, a reflection is needed with regard to the feminist approach used in this study that advocates for female trauma survivors’ interests. This stance has been encouraged in previous research in this field (e.g., Campbell et al., 2010; Hall, 2011; Smith, 2014). Yet, a tension emerged for me as the researcher in this study that needed to be consciously addressed in my research diary to maintain reflexivity in data generation and analysis. Siding with trauma survivors can lead to the temptation to judge perpetrators negatively without knowing their side of the story or enough about the wider circumstances in which the abuse occurred. This can be problematic because one might stigmatise perpetrators who themselves may have been abused or neglected. These perpetrators may have abused or neglected the participating trauma survivors because their own traumatic history may have led them to cope with stressful situations in an aggressive way. This idea is supported by research that has associated hostile and criminal behaviour with exposure to prior traumatic life experiences (e.g., Birkley et al., 2016; Johnson & Lynch, 2013; Maercker & Hecker, 2016). My study was not constructed to address this complexity. This observation does highlight that great care needs to be taking in this field of research and practice to prevent social exclusion of perpetrators, and to keep a balanced view.
5.6. **Future directions**

Future research arises from the present study. Five key suggestions are proposed. Firstly, future quantitative studies could examine key factors and processes that emerged in this study and test these in a larger population of trauma survivors. This might also include investigations of cause and effect. Interesting research questions could include: Does ‘making trauma and abuse visible’ decrease distress in circumstances of supported self-management compared with circumstances of self-guided self-management? Is ‘disengagement’ reduced with increased social support? Does support from others reduce survivors’ shame, guilt and self-blame, mediated by a shift in responsibility? Furthermore, longitudinal studies could explore at what point these changes occur. Two important considerations apply to quantitative follow-up studies, namely, (1) that research simultaneously assesses groups for differences by trauma types to allow comparison, and (2) that researchers include relevant contextual factors.

Secondly, when analysing transcripts of this study a hypothesis emerged proposing that trauma survivors appeared to reflect less when levels of self-guided self-management were high, and to reflect more when supported self-management was high (i.e., when they used supportive others to ‘make trauma and abuse visible’, to ‘examine’ it and to ‘reconstruct reality’). Follow-up quantitative research could explore this hypothesis by analysing interview transcripts of this study for trauma survivors’ reflective functioning through examining the use of reflective and non-reflective words. Instructions from Fonagy, Target, Steele, and Steele’s (1998) Reflective-Functioning Manual may serve as rating tool.

Thirdly, future work is needed to explore social structures and social networks in order to map the complex interactions between individuals, groups and society as a whole (Bryant, 2016). Understanding wider social factors and processes is particularly relevant in light of the findings of this study where survivors’ recovery
was influence profoundly by supportive others. Bryant (2016) argued that social network analysis has not been applied to research of post-traumatic stress and trauma recovery before; however, valuable insights into social factors have been gained from studies on other mental health and general health issues. Similarly, future research is required to increase the evidence base for the effectiveness of community programmes in order to understand what community factors help to identify, prevent, and reduce interpersonal violence and trauma (Bourey et al., 2015; DeGue et al., 2012; Mannell & Dadswell, 2017; van Dijken et al., 2015).

In addition, research on the benefit of recreational and mindfulness-like activities on trauma recovery is worthwhile pursuing. Activities, such as taking pictures, writing, listening to music, yoga and exercising, were frequently mentioned by study participants. Research could investigate relationships between these activities, and ‘making trauma and abuse visible’ (similar to existing concepts of ‘awareness’ and ‘attention’), ‘examining’ one’s trauma and abuse (similar to existing concepts of ‘reflective functioning’ or ‘reappraisal’), reducing PTSD, and increasing emotion regulation and interpersonal skills. With the exception of studies on expressive writing and PTSD, current research in this area is sparse (e.g., Nolan, 2016).

Finally, a social reconstruction model of trauma recovery may also be able to explain some other life experiences with broad similarities, for example, bullying at school or work. It can be used as the basis of research into interpersonal trauma in less recognised groups, such as men, ethnic minorities, refugees, victims of human trafficking and sexting, homeless people and imprisoned offenders. In the future, studies could examine which factors and processes of the new model map onto these groups and which factors and processes need adapting. In particular, trauma research with male survivors is increasingly called for. This is because prevalence studies are becoming better at identifying abused men and beginning to reveal that there are higher rates of exposure to child maltreatment, intimate partner violence,
and trauma among men than previously thought (Lillywhite & Skidmore, 2006; Thomas & Speyer, 2016).

### 5.7. Contribution to knowledge and conclusion

This piece of research explored how adults with a history of interpersonal trauma recover and, particularly, what processes and factors were involved that facilitated a shift from emotion regulation and interpersonal difficulties to emotional and interpersonal competence. An initial literature review included an account of the prevalence and definitions of interpersonal trauma, symptomatology, emotion dysregulation, interpersonal deficits and treatment approaches. It revealed that violence against women and children is a widespread global challenge, and those who suffer are, as a result, likely to develop long-term complex mental and physical health and social problems. Post-traumatic stress and difficulties managing distressing emotions and relating to others have been reported frequently. Therefore, it is imperative to understand the key elements and processes that facilitate trauma recovery. Previous research and theories attempted to provide explanations (e.g., attachment, resilience, coping). However, they fall short in that they viewed trauma and recovery predominantly as a problem within the individual. They did not appropriately consider the role of context, external factors and social processes. Also, factors and processes specific to two key aspects – emotion regulation and relatedness – remain relatively unknown. In addition, the majority of trauma research is built on retrospective self-report questionnaires which comes with a range of methodological limitations that have not been challenged by using alternative methods. Self-reports further emphasise the intrapsychic focus. Thus, the current understanding in this area remains limited. Trauma recovery is undoubtedly more complicated.
This study explored key elements and processes of trauma recovery in adult survivors with a focus on emotional and interpersonal skills, through the narratives of individuals constructing their own recovery within an interpersonal context. Fifteen adult survivors were recruited from a statutory clinical service and a third-sector community project. Participants were interviewed individually, and data were analysed using grounded theory.

Findings revealed four key components including ‘disengaging’ from feelings, other people and oneself, ‘making trauma and abuse visible’, ‘examining’ it, and ‘reconstructing reality’. While these components covered emotional and interpersonal coping strategies, they place particular emphasis on cognitive coping strategies. This work has confirmed the importance of cognitive processing and intrapsychic aspects in trauma recovery highlighted in previous literature. However, this study contributes to existing knowledge in that these four key components revealed a step-by-step cognitive approach to processing and reconstructing trauma experiences. This is important because this understanding allows survivors and health professionals to target specific stages within cognitive trauma processes which previously have been summarised only as ‘cognitive processing’ or ‘cognitive reappraisal’. In addition, this study highlighted that cognitive processing of trauma cannot be attributed to survivors alone but that the interaction between individual survivors and a supportive environment substantially altered how experiences of trauma, emotions and relationships were processed.

Findings also identified four subthemes to ‘reconstructing reality’. These advance our understanding because they describe what is initially appraised and later reappraised in the recovery process and because they demonstrate the crucial role supportive others take in collaboratively reconstructing different aspects of survivors’ reality. Through social interaction, (1) survivors reconstructed abuse and trauma-related difficulties, (2) they reframed choice and control, (3) they
reconstructed how they as survivors viewed themselves as person, and (4) they shifted and shared responsibility for the abuse and trauma.

Most importantly, this framework revealed a gradual, non-linear transition from self-guided to supported self-management and, thus, stressed the relational and multifaceted nature of trauma recovery that has been neglected until recently. Survivors sought out relationships, were impacted by relationships, and these relationships changed the way survivors responded. Similarly, survivors reframed emotional and interpersonal difficulties and gradually managed these through relationships. What is more, this social reconstruction model of trauma recovery can be expanded to incorporate wider societal and cultural factors and processes. Survivors may seek out institutions and governments for help, may be impacted by these, and these authorities may change the way survivors respond to trauma. This is important to realise as it has implications for organisational practices, and for policies.

Above all, policy and practice changes need to occur in community settings and on a larger societal and cultural level. Findings indicated that the main responsibility for recovery should not be attributed to the individual survivor. This might be understood by survivors as further neglect and only serves to exacerbate a sense of stigma, social exclusion, worthlessness, and feelings of shame. Instead, trauma recovery requires widespread and collaborative social solutions. While future research could examine components and processes of this social reconstruction model, priority should be given to investigating the role of context, external factors and social processes in trauma research overall. Only when both the role of the individual and the role of other people in trauma recovery is understood can adequate support be provided in order for survivors of interpersonal trauma to recover and thrive.
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Appendices

Appendix A: Recruitment poster for community site

Recovery Journeys Following Abuse
Looking for research participants

Researchers at the University of Edinburgh would like to invite people to take part in a research study. This research aims to understand how people recover after having experienced abuse and trauma.

Do you fit these criteria?
- aged 18 years or older
- having had a traumatic experience of abuse or neglect
- currently seeking help and working towards getting better as a result of this

In this study you will be asked to:
- take part in a one-to-one interview with a researcher to share your recovery experience so far
- complete a brief demographic questionnaire

If you would like to find out more details or are interested in taking part, please contact Anke at [email address] or call [research phone number] or visit www.traumarecoveryresearch.wordpress.com for more information. Feel free to also contact us for advice if you are not sure whether you are eligible.
Appendix B: Recruitment poster for clinical site

Are you recovering from trauma?
Looking for research participants

I am a doctoral research student at the University of Edinburgh and would like to invite you to take part in my study. My research aims to understand how people get well after having experienced abuse and trauma. Findings will help improve future treatment.

I am looking for people who:

- are over 18 years old
- had a traumatic experience that involved, for example, abuse, assault, domestic violence, childhood adversity or neglect, and
- are currently seeking help and are actively striving towards getting well as a result of this experience

In this study you will be asked to:

- take part in an interview with myself and share what helped you so far to get well
- complete a brief background questionnaire

Information you give will be anonymised and kept confidential.
If you would like to find out more details or are interested in taking part, please contact me at [email address] or call [research phone number] or visit www.traumarecoveryresearch.wordpress.com for more information. Feel free to also contact me for advice if you are not sure whether this study is for you.

Thank you. Anke
Appendix C: Advertisement for community site’s social network page online

Hi everyone. I am doing a study on how people recover after having experienced abuse and trauma. This is part of my course at university. I am looking for adults who have received support from [this community] before and would be interested in completing a short questionnaire and in taking part in a one-to-one interview with me. In the interview you will be asked to share your experience of how you got better after a traumatic experience of abuse or neglect. If you would like to find out more details or would like to take part, please contact me directly on [email address] or [research phone number], visit [recruitment website], or speak to me in the [community space] on a Wednesday or to [staff member]. Thank you.
Appendix D: Letter of invitation (clinical site)

Recovery Journeys Following Interpersonal Trauma

We would like to invite you to take part in our research study.

This research aims to explore how people recover after having experienced abuse. Before you decide whether or not to take part in this research we would like you to understand why the research is being done and what it involves. Please read the provided information carefully. If you would like to, it may be helpful to talk to your family or friends about taking part in this research. If you have any questions, please contact us.

Anke Kossurok, Doctoral Researcher
School of Health in Social Science
University of Edinburgh
Email: [email address]
Tel.: [research phone number]
Appendix E: Participant information sheet (clinical site)

Recovery Journeys Following Interpersonal Trauma
Participant information sheet

What is the purpose of this study?
Experiencing abuse can have negative consequences on a person’s life. Emotional and social difficulties are common. The purpose of this study is to find out about trauma survivors’ recovery journey and, particularly, how day-to-day life is managed and relationships are affected.

Who is organising and funding this research?
This research is conducted by a doctoral research student at the University of Edinburgh. It is supervised by Prof Matthias Schwannauer and Dr Stella Chan and funded by the associated studentship from the University of Edinburgh.

Why have you been asked to take part?
This study aims to include English speakers over 18 years old who have experienced an abusive event, and who are actively seeking help (for example, by participating in therapy or psycho-educational courses or by regularly participating in support groups). Abusive events could take many forms. They could be experiences where you were hurt physically, sexually, emotionally, or when your emotional or physical needs were neglected, or any similar experiences.

Do you have to take part in this research?
No, you do not need to take part in this research study. Participation in this study is entirely voluntary and will not affect the care or treatment you receive in any way. If you say ‘yes’ the doctoral researcher will meet and ask you to sign a consent form. You will be given at least 24 hours between reading this information sheet
Making the invisible visible: A grounded theory study...

and being asked to give consent. This will allow you time to ask others and consider taking part in this study. You are free to change your mind and stop being a part of this research study at any time, without having to give a reason. With your consent, we will advise your GP of your participation in this study.

**What will happen if you decide to take part?**
The doctoral researcher will arrange a time and place to meet you. You will be asked to take part in a one-to-one interview where you will be invited to share your recovery experience in a confidential space. The interview will be audio-recorded for research purposes. Following this, the researcher will ask you to complete a demographic questionnaire about your background information such as gender and age. Then you will be given the opportunity to ask any questions and raise any concerns (if any). In total this is likely to take 1-1.5 hours. We may wish to contact you again for feedback. However, you decide if you want us to.

**What are the possible disadvantages or risks of taking part?**
In the interview you will be asked how you have coped with the experience of abuse and trauma afterwards. Although the focus of this research is on reflecting on your journey towards recovery, some questions may also ask you to reflect on the negative consequences of your trauma experience. Talking about these consequences may bring about uncomfortable memories for some people. This is an understandable reaction. However, the risk is minimal and no greater than those normally encountered in daily life. If you find yourself becoming upset you are free to take a break or stop the interview at any time.

**What will happen if you do not want to carry on with the study?**
You can decide to withdraw from the study at any stage. This decision will not impact on the level of care you receive. If you do decide not to carry on, any information collected up to your withdrawal may still be kept and used for analysis.

**What are the possible benefits of taking part?**
The information we get from this study will allow us to understand more about how people recover and will help improve the treatment for trauma survivors. As a participant, you may gain personal insight and meaning by talking about your experience. Also, if you are interested we would be happy to provide you a
summary of the overall research findings. At the end of the study you will receive a £10 retail voucher as a thank-you from us.

**Will your taking part in this study be kept confidential?**
Yes. We will follow ethical and legal practice and all information about you will be handled in confidence. The audio recording will be done on a password-protected recorder. It will be transferred to a secure computer and deleted from the recorder as soon as possible after the interview. The recording will be transcribed and any identifiers will be removed from this transcript so that it will not be possible for anyone to identify you. The transcript and the questionnaire will only contain a participant number. All data will be stored in a secure office and on computers that are password protected. Only the named researchers will know your name and will be able to identify you. Personal data will be kept for up to 3 years and then securely destroyed.

The findings of this research will be written up as thesis, and may be published in academic journals and at conferences, and shared with other organisations; however, your name or other personal information **will never be disclosed**.

However, if concern arises for your safety or a risk of harm to others based on what you shared during the study then confidential information will have to be disclosed to a member of your care team. Please be assured that the researcher will discuss this with you first before information is shared in this case.

**Who has reviewed this research?**
This research has been reviewed by the South East Scotland Research Ethics Committee 01, which consists of an independent body of individuals to protect your rights and safety. This study has been approved by the South East Scotland Research Ethics Committee 01.

**Where can you get further information about this research?**
If you would like to find out further information about this research or would like to take part, please contact Anke Kossurok, doctoral researcher, School of Health in Social Science, University of Edinburgh, [research phone number], [email address]. Feel free to also contact her for advice if you are not sure whether you are eligible. If you would like to talk to someone outside the research team for independent
advice please contact Helen Griffiths, Senior Teaching Fellow, Clinical Psychology, on [phone number] or email [email address].

**What do you do if you wish to make a complaint?**

If you have a concern about any aspect of this research you can contact one of the supervisors of this study, Prof Matthias Schwannauer on [phone number] or email [email address], who will do his best to resolve any issues. If you wish to make a complaint about the study please contact NHS Lothian:

- NHS Lothian Complaints Team
- 2nd Floor, Waverley Gate
- 2-4 Waterloo Place
- Edinburgh, EH1 3EG
- Tel: 0131 465 5708
- Email: craft@nhslothian.scot.nhs.uk

*Thank you for taking the time to read this information sheet.*
Appendix F: Participant consent form (clinical site)

Recovery Journeys Following Interpersonal Trauma
Consent form

Name of researchers: Anke Kossurok (Chief Investigator), Prof Matthias Schwannauer (Principal Academic Supervisor), Dr Stella Chan (Second Academic Supervisor)

Please initial all boxes

1. I confirm that I have read and understood the Participant Information Sheet dated 09/09/2015 (version 04) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.

3. I understand that relevant sections of my medical notes and data collected during the study may be looked at by individuals from the Sponsor (University of Edinburgh), from the NHS organisation or other authorities, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.

4. I agree to my anonymised information being analysed and parts of it (including, for example, quotations) being published in journals and at conferences, and shared with other organisations. I understand that my personal information will not be disclosed.

5. I understand the interviews will be recorded and typed out word for word. I give permission for this to be done.

6. I understand that the recordings will be destroyed once the interviews have been analysed.
7. I agree to my GP being informed of my participation in the study.  

8. I agree to take part in the above study.

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Appendix G: Demographic questionnaire (clinical site)

Recovery Journeys Following Interpersonal Trauma
Demographic questionnaire

Please provide us with information to the following questions. The answers will help us gain an overview of your circumstances.

1. How old are you? _______

2. What is your gender? Please give only one answer.
   - female
   - male

3. Are you currently in full-time education? Please give only one answer.
   - yes
   - no

4. What is the highest education you have attained? Please give only one answer.
   - no formal education
   - primary school education
   - secondary school education
   - tertiary education (e.g., college, university)
   - prefer not to say
5. **What is your current work situation?** For this question, please tick all that currently apply to you.
   - [ ] unemployed
   - [ ] employed (part-time)
   - [ ] employed (full-time)
   - [ ] self-employed
   - [ ] prefer not to say

6. **What is your current marital status?** Please give only one answer.
   - [ ] single
   - [ ] married or in a civil partnership
   - [ ] in a relationship
   - [ ] prefer not to say

7. **Do you have children?** Please give only one answer.
   - [ ] yes. How many children do you have? _______
   - [ ] no
   - [ ] prefer not to say

8. **Who do you live with?** For this question, please tick all that currently apply to you.
   - [ ] children
   - [ ] partner/spouse
   - [ ] parents
   - [ ] other relatives
   - [ ] friends
   - [ ] living on my own
   - [ ] other: ________________________________
   - [ ] prefer not to say
9. What is your ethnic background? Please give only one answer.

- White
- Asian (e.g., Indian, Bangladeshi, Pakistani, Chinese)
- Black (e.g., African, Caribbean)
- Arabian
- mixed
- other: ___________________________________________
- prefer not to say
Appendix H: Debriefing sheet (clinical site)

Recovery Journeys Following Interpersonal Trauma
Debriefing statement

Thank you for taking part in this research study.

We are looking to understand more about how individuals recover after experiencing abuse and trauma and, particularly, what helps to cope with emotional experiences and social relationships. The results will allow us to understand more about these core difficulties after trauma and this will help us think about how to improve wellbeing in the long run.

In a study like this, we do not routinely provide individual feedback to participants, because we are looking at the responses as a whole group. We would be happy to provide a summary of the overall research findings. If you are interested in receiving a copy of the summary, or if you have any comments, please let the researcher know.

Talking about these difficult experiences may trigger memories that often make a person feel upset. If sharing your experience in this study has left you with concerns or worries, it may be helpful for you to talk to a mental health professional. If you are not supported by a mental health service, you may find it helpful to talk to your GP, to NHS 24 (phone 111) or the Mental Health Assessment Service (24-hour service at Royal Edinburgh Hospital, 0131 537 6000).

There are also some local organisations that provide support for people who may be experiencing psychological difficulties; we include some information below:

**Samaritans.** Provides confidential non-judgemental emotional support. There is a local branch in Edinburgh, 25 Torphichen Street, usually open from 9am-10pm. Their contact number is 0131 221 9999. There is also a national hotline number
08457 90 90 90. You can find out more information from their website: http://www.samaritans.org

**Breathing Space.** Confidential phone and web-based support for people experiencing low mood, depression or anxiety. They operate Monday-Thursday 6pm-2am, and Friday 6pm – Monday 6am. Their contact number is 0800 83 85 87. Or visit: http://www.breathingspacescotland.co.uk/

You may also find the following helpful: **Scottish Women’s Aid** (for women; helpline 0800 027 1234, Edinburgh branch 0131 315 8110), **AMIS - Abused Men in Scotland** (for men; helpline 0808 800 0024, Edinburgh branch 0131 447 7449), and **Open Secret** (0132 463 0100).
Appendix I: Researcher form collecting participants’ general practitioner details, permission to invite later feedback, and interest for receiving study summary

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<td><strong>Permission to be contacted again</strong></td>
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Appendix J: Letter to general practitioner (clinical site)

[GP’s name]
[Name of Surgery]
[Address line]
[Town]
[Postcode]
[Date]

Dear [GP’s name],

This is to notify you that [Participant’s full name] took part in the psychological study “Recovery journeys following interpersonal trauma”. [Participant’s first name] informed us that he/she is registered at this surgery. As part of the ethics procedure for this research, I attach the study’s information sheet for your records.

If you have any questions, please do not hesitate to contact us.

[Signature]
Ms Anke Kossurok
Doctoral Research Student
Clinical Psychology
School of Health in Social Science
University of Edinburgh
Doorway 6, Medical Quad
Teviot Place, Edinburgh, EH8 9AG

Tel.: [research phone number]
Email: [email address]
Appendix K: Research summary for participants (clinical site)

Research Summary:

Recovery Journeys Following Interpersonal Trauma

Dear [name],

Thank you for taking part in the study “Recovery Journeys Following Interpersonal Trauma” in [month] [year]. It was insightful and a privilege to listen to your story. You indicated that you wish to receive a summary of this research. These are the overall results to date:

Research aim
This study asked how adults recover from experiences of interpersonal trauma and what ingredients facilitate this healing process. In particular, managing emotions and interpersonal aspects in day-to-day life are known to be problematic, and this study explored how emotional and interpersonal skills can be gained following abuse and trauma.

Background information
You were one of 15 women interviewed in 2015/2016 about their journey after trauma and abuse. Women’s age ranged from their early 20s to their 60s. Almost all disclosed some form of abuse or neglect in childhood (seven reporting child sexual abuse in particular); three stories focused on intimate partner violence.

Day-to-day difficulties
As a group, you reported experiencing a variety of day-to-day difficulties (currently or in the past), such as having flashbacks, isolating and avoiding
people, feeling intense and repeated confusion, frustration, anger, anxiety, numbness and/or depression for a period in your life, being in abusive/exploitative intimate relationships (often repeatedly), generally distrusting others, dissociating, self-harming and feeling suicidal, and misusing drugs or alcohol. Particularly dominant were experiences of shame, self-blame and low self-worth. While not all of these were experienced at any one time, it appeared that several of them impacted on day-to-day life (e.g., work, studies, finances, parenting, and attending appointments), often over several years. These difficulties are known to trauma-informed professionals and researchers.

There appear to be five key strategies in addressing these difficulties. Some of them are central when managing difficulties by oneself (what we have called ‘self-guided self-management’), others when managing difficulties with the help of others (‘supported self-management’), and some overlap.

**Self-guided self-management**

**Strategy 1: avoiding/escaping.** Several day-to-day difficulties resembled ways to adapt in stressful situations by escaping them. For example, when distrusting, isolating from, and being too nice to others, confrontations with others were avoided and distress seemed reduced. Similarly, dissociating, using alcohol/drugs, or self-harming looked like escaping emotional pain and thereby reducing it. Particularly before seeking/receiving help, there seemed to be many varied and resourceful ways to avoid/escape distress. But distress did not appear to be solved longer term and, instead, resurfaced frequently. By contrast, seeking/receiving help seemed to minimise escape strategies when alternative resources became available for facing life difficulties.

**Strategy 2: distancing from the abuser.** Some of you distanced yourself from the person(s) who harmed you by moving away from them, stopping any contact, or renaming the abuser (e.g., not ‘my ex-partner’, but ‘my children’s father’). This appeared to be an intentional and difficult decision between either staying in a known but unsafe place, or leaving danger to face uncertainty.

**Strategy 3: making internal experiences visible.** You spoke of pursuing activities by yourselves that seemed to transform the internal, invisible and distressing experiences into more tangible and visible forms. For example, some of you wrote poetry or journals, took images, exercised, meditated, or listened to music.
to ‘get it out’. This appeared to release emotional stress and make difficulties available for closer examination.

**Strategy 4: examining and reconstructing.** Everyday difficulties, emotional distress, the effects on oneself from interactions, and sometimes the abuse experience were examined. This involved questioning these, tracing difficulties back to stressful events, or reading about trauma, abuse and the brain. Through this examination, a reconstruction seems to begin of how the abuse incident and the subsequent trauma is viewed.

Variations of strategy 3 and 4 surface during ‘supported self-management’. Their features will be addressed below.

**Supported self-management**
Supportive others – usually 1-2 significant people – involved trauma-informed professionals (e.g., GPs, CPNs, and psychologists), peer survivors, friends, family, and neighbours.

**Strategy 3: making internal experiences visible.** Talking to supportive others about your current life difficulties and about the abuse experienced in the past seemed to be important. Again, it looked like a way to ‘get it out’, and make these visible and accessible for examination. Listening to other trauma survivors talk appeared to bring internal experiences into focus when identifying with them. Sometimes this was insightful and valuable, occasionally it was upsetting.

**Strategy 4: examining and reconstructing.** Supportive others appeared to enhance self-examination by inquiring about day-to-day difficulties, feelings, perceptions, reactions and interactions, and the experience of abuse; but also by providing information on these or affirming your experience. Sometimes this felt
challenging, sometimes soothing. Through supportive examination, abuse and subsequent trauma came to be understood differently:

Initially, abuse seemed to be understood as your fault, as deserved, as normal/legitimate; but then became reconstructed as not normal, and not your fault. Also initially, there was a sense that you believed you will continue to suffer, that these day-to-day difficulties will never cease, or that everyone experiences this; but then this became reframed as normal reactions to an abnormal experience and that these can go away.

**Strategy 5: shifting and sharing responsibility.** Reconstructing the abuse/trauma experience, seemed to alter what you feel responsible for: Instead of feeling responsible and blaming yourself for both the abuse and for not managing life afterwards, the responsibility for the abuse seemed to shift from you onto the person who harmed you, and the responsibility for your healing seemed to be shared with supportive others. Lifting this double burden appeared to leave space to take better care of yourself, while also reducing shame and increasing self-worth.

**Disclosure and initial help-seeking**

Disclosing abuse or seeking help for day-to-day difficulties from someone for the first time built the bridge between self-guided and supported self-management. Disclosure and help-seeking appeared to be a fragile moment with mixed experiences ranging from being ignored or not believed, and professionals addressing isolated symptoms but not the trauma/abuse history, to others acknowledging distress, others actively reaching out to provide practical help, information or comfort, and making available multiple ongoing support.

Overall, there was the impression that seeking and receiving adequate help was vital because it reduced the domineering escape strategies and the shame, focused increasingly on talking through and reconstructing traumatic experiences, and built a stronger sense of self. The ultimate goal of the recovery journey seemed to involve living a full life where one feels valuable and able to participate in, for example, work/study, family life and relationships.

**Request**

It is part of the research plan to obtain feedback on these results. This will help us better understand where we got it right and where our interpretation of results
needs correcting. Therefore, I was wondering if you would be willing to provide feedback in an email, a prearranged phone conversation, or face-to-face at [research site] where I would be happy to talk to you up to the 2nd April 2017. This will give me time to include your anonymous feedback in my thesis.

Thank you again for having taken part. It was much appreciated.

Looking forward to hearing from you. Kind regards,
Anke

Anke Kossurok, Doctoral Researcher
Clinical Psychology
School of Health in Social Science
University of Edinburgh
Doorway 6, Medical Quad
Teviot Place, Edinburgh, EH8 9AG
Email: [email address]
Tel.: [research phone number]
## Appendix L: Development and refinement of categories and sub-categories over time (table 1 of 8)

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<td>misusing leads to anger, indifference, ill-health, not living, trouble for oneself</td>
<td>misusing leads to problems in relationships</td>
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<td>Connection between addiction and trauma recovery</td>
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<td>with sobriety, trauma memories come to the foreground</td>
<td>drinking or drugging to cope with trauma experience</td>
<td>Connecting food with trauma</td>
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<td>Praising services</td>
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<td>Mental shifts, and learning about trauma and oneself</td>
<td>Naming it</td>
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<td>Awareness, realisation</td>
<td>Being challenged, confronted</td>
<td>Developing strategies</td>
<td>Getting it out</td>
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<td>Defining recovery</td>
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<td>Denying or avoiding trauma processing</td>
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<td>Disowning or distancing from abuser</td>
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<td>Disowning and distancing from abusers</td>
<td>Disowning the other by relabelling relationships</td>
<td>Distancing can lead to missing out</td>
<td>Staying away from a sick friend</td>
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<td>Ambiguity, ambivalence,</td>
<td>Doing or experiencing something helpful despite it being challenging</td>
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<td>attempting to manage flashbacks</td>
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<td>identifying and receiving support with flashbacks in conversations with others</td>
<td>by rationalising</td>
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<td>associated with environment and people</td>
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<td>feeling confused, disconnected, disoriented after flashbacks</td>
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<td>Date</td>
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<tr>
<td>Jul 2016</td>
<td>experiences positive feelings with people and services today</td>
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<tr>
<td>Aug 2016</td>
<td>feeling grateful today</td>
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<tr>
<td>Sep 2016</td>
<td>feeling joy and excitement today</td>
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<tr>
<td>Oct 2016</td>
<td>feeling confused, frustrated, numb and inhibited generally</td>
<td></td>
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<td></td>
<td></td>
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<td></td>
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<tr>
<td>Nov 2016</td>
<td>feeling panic and anxiety (generally or specifically)</td>
<td></td>
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<td>Apr 2017</td>
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</tbody>
</table>

**Internal processing of trauma**

<table>
<thead>
<tr>
<th>Blaming in interpersonal context</th>
<th>(discontinued)</th>
</tr>
</thead>
<tbody>
<tr>
<td>forgiving</td>
<td></td>
</tr>
<tr>
<td>identifying with others</td>
<td></td>
</tr>
<tr>
<td>justifying</td>
<td></td>
</tr>
<tr>
<td>Self</td>
<td></td>
</tr>
<tr>
<td>finding words for it</td>
<td></td>
</tr>
<tr>
<td>I don't know, Don't</td>
<td></td>
</tr>
<tr>
<td>identifying needs</td>
<td></td>
</tr>
<tr>
<td>knowing, being certain about</td>
<td></td>
</tr>
<tr>
<td>something</td>
<td></td>
</tr>
<tr>
<td>Looking at experiences</td>
<td></td>
</tr>
</tbody>
</table>

**Goals and activism**

| Identifying with others          |                                                                 |
|                                  | (moved elseware)                                               |
|                                  | false hope                                                     |
|                                  | negative cases                                                 |

**Forgiving oneself, others, and what happened**

<table>
<thead>
<tr>
<th>Forward-backward-forward movements</th>
</tr>
</thead>
<tbody>
<tr>
<td>---</td>
</tr>
<tr>
<td>Goals and activism</td>
</tr>
<tr>
<td>Hope</td>
</tr>
<tr>
<td>Identifying with others</td>
</tr>
<tr>
<td>identifying with others brings</td>
</tr>
<tr>
<td>hope, freedom, relief</td>
</tr>
</tbody>
</table>

**Making the invisible visible: A grounded theory study...**

**Appendices**

**Table 5 of 8**

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nov 2015</td>
<td></td>
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<tr>
<td>Dec 2015</td>
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<tr>
<td>Feb 2016</td>
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<td>Mar 2016</td>
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**Internal processing of trauma**

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<thead>
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<tr>
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<tr>
<td>something</td>
<td></td>
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<tr>
<td>Looking at experiences</td>
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</tbody>
</table>

**Goals and activism**

| Identifying with others          |                                                                 |
|                                  | (moved elseware)                                               |
|                                  | false hope                                                     |
|                                  | negative cases                                                 |

**Forgiving oneself, others, and what happened**

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<tbody>
<tr>
<td>Goals and activism</td>
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<td>Hope</td>
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<tr>
<td>hope, freedom, relief</td>
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</tbody>
</table>

**Making the invisible visible: A grounded theory study...**

**Appendices**

**Table 5 of 8**
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>still affected today</td>
<td>(moved elsewhere)</td>
<td>being in control and able to choose</td>
<td>(moved elsewhere)</td>
<td>resisting, being challenged, being</td>
<td>(moved elsewhere)</td>
<td>(moved elsewhere)</td>
<td>Isolating, being on my own</td>
<td>negative cases</td>
<td>feeling less alone</td>
<td>wanting to be</td>
</tr>
<tr>
<td>Learning</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>Justifying or excusing others lack of time or care</td>
<td>odd cases</td>
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</tr>
<tr>
<td>learning about info or behaviour in IP context</td>
<td>(discontinued)</td>
<td>learning about oneself</td>
<td>(discontinued)</td>
<td>learning about oneself in IP context</td>
<td>(discontinued)</td>
<td>learning in interpersonal context</td>
<td>(discontinued)</td>
<td>learning information or behaviour</td>
<td>(discontinued)</td>
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<tr>
<td>Lightbulb moments, turning points</td>
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<tr>
<td>Living live today</td>
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<td></td>
<td></td>
<td>Looking at experiences to make sense</td>
<td>odd cases</td>
<td>(not looking)</td>
<td>looking at exp</td>
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<tr>
<td>beliefs about the world</td>
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<tr>
<td>processing feelings</td>
<td>Assumpti</td>
<td>Making assumptions about trauma and recovery</td>
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<tr>
<td>comparing, ...</td>
<td>... differentiating, contextualising feelings</td>
<td>Making sense of and managing feelings</td>
<td>attempting to manage feelings</td>
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<tr>
<td>not processing, or mismanaging feelings - negative cases</td>
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<td>avoiding, num destroying one doing it alone</td>
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<tr>
<td>Making the invisible (internal) visible (external)</td>
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<tr>
<td>negative cases (making an experience invisible)</td>
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<td>Memories and remembering</td>
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<tr>
<td>flashback memories and other unpleasant memories</td>
<td>active remembering</td>
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<tr>
<td>forgetting, vagueness</td>
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<tr>
<td>forgetting</td>
<td>being vague; generalising</td>
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## Table 7 of 8

<table>
<thead>
<tr>
<th>Month</th>
<th>Event Description</th>
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</thead>
<tbody>
<tr>
<td>Nov. 2015</td>
<td>Negative interpersonal contact actively contributing to it</td>
</tr>
<tr>
<td>Dec. 2015</td>
<td>Saying no</td>
</tr>
<tr>
<td>Jan. 2016</td>
<td>dishes escaping being given to others (social interaction)</td>
</tr>
<tr>
<td>Feb. 2016</td>
<td>Ignoring the existence of the abuse</td>
</tr>
<tr>
<td>Mar. 2016</td>
<td>Feeling uncomfortable with discussing the abuse</td>
</tr>
<tr>
<td>Apr. 2016</td>
<td>Feeling uncertain about what to do</td>
</tr>
<tr>
<td>May 2016</td>
<td>Feeling frightened</td>
</tr>
<tr>
<td>June 2016</td>
<td>Feeling helpless</td>
</tr>
<tr>
<td>July 2016</td>
<td>Feeling isolated</td>
</tr>
<tr>
<td>Aug. 2016</td>
<td>Feeling lonely</td>
</tr>
<tr>
<td>Sep. 2016</td>
<td>Feeling ashamed</td>
</tr>
<tr>
<td>Oct. 2016</td>
<td>Feeling guilty</td>
</tr>
<tr>
<td>Nov. 2016</td>
<td>Feeling hurt</td>
</tr>
<tr>
<td>Dec. 2016</td>
<td>Feeling scared</td>
</tr>
<tr>
<td>Jan. 2017</td>
<td>Feeling anxious</td>
</tr>
<tr>
<td>Feb. 2017</td>
<td>Feeling depressed</td>
</tr>
<tr>
<td>Mar. 2017</td>
<td>Feelingipi</td>
</tr>
<tr>
<td>Apr. 2017</td>
<td>Feeling overwhelmed</td>
</tr>
</tbody>
</table>

**Note:** The table above outlines various psychological states and experiences related to abuse, highlighting common emotional reactions and behavioral patterns observed in abuse survivors. The entries in the table represent different stages and facets of emotional and psychological responses to abuse.
<table>
<thead>
<tr>
<th>Tool</th>
<th>Tool box (behavioural, practical, external aspects)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Talking about coping tools</td>
</tr>
<tr>
<td></td>
<td>Doing EMDR</td>
</tr>
<tr>
<td></td>
<td>Relating to others</td>
</tr>
<tr>
<td></td>
<td>Reading</td>
</tr>
<tr>
<td></td>
<td>Tracing back</td>
</tr>
<tr>
<td></td>
<td>Using affirmations</td>
</tr>
<tr>
<td></td>
<td>Help (mov) engaging in art, music or writing</td>
</tr>
<tr>
<td></td>
<td>Trust</td>
</tr>
<tr>
<td></td>
<td>Validation, acceptance, recognition, identification</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Month</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nov 2015</td>
<td>finding it hard to talk about it to someone not talking about it (merged with outcomes of talking about it to someone talking about trauma and recovery)</td>
</tr>
<tr>
<td>Dec 2015</td>
<td>talking to oneself</td>
</tr>
<tr>
<td>Feb 2016</td>
<td>talking with others (generally)</td>
</tr>
<tr>
<td>Mar 2016</td>
<td>negative cases (not talking with Thinking not logical)</td>
</tr>
</tbody>
</table>
| Apr 2016 | Developing ways to cope (generally) and finding this simple, hard, silly, sceptical, doing art doing EMDR looks at, gains control and distance from trauma memories doing meditation, mindfulness, yoga exercising and eating knitting to do and achieve learning to relate to others, generally listening to music reading about trauma, abuse, reading and watching videos about trauma, abuse, taking pictures effects of tracing back - understanding, derestrifying negative cases (looking forward) walking outside to fill the writing negative cases (having no having no or dy (discontinued) Trust negative cases testing out if someone can be trusted testing out if someone Distrusting others being cautious or a Using humour for general validation trauma-specific
## Appendix M: Final category structure

This table shows the final categories (dark grey rows, uppercase letters) and subcategories (medium and light grey rows) in hierarchical structure as created in NVivo.

<table>
<thead>
<tr>
<th>Category name</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>EXPERIENCING ADDICTIONS</strong></td>
</tr>
<tr>
<td>misusing drugs, alcohol and meds</td>
</tr>
<tr>
<td>denying, not seeing addiction as problem</td>
</tr>
<tr>
<td>misusing to solve problems, cope, please, forget</td>
</tr>
<tr>
<td>misusing leads to anger, indifference, ill-health, not living, trouble for oneself</td>
</tr>
<tr>
<td>misusing leads to problems in relationships</td>
</tr>
<tr>
<td>turning point to stop misusing substances</td>
</tr>
<tr>
<td>stopping substance misuse to be well, be in control, have a life</td>
</tr>
<tr>
<td>stopping and starting addiction and recovery from it</td>
</tr>
<tr>
<td>doing addiction recovery</td>
</tr>
<tr>
<td>doing recovery with professionals and peers</td>
</tr>
<tr>
<td>staying sober</td>
</tr>
<tr>
<td>multiple treatments</td>
</tr>
<tr>
<td>feeling hesitant, anxious, apprehensive about doing recovery</td>
</tr>
<tr>
<td>sharing experiences and identification brings relief, strength, courage etc.</td>
</tr>
<tr>
<td>stopping substance misuse is scary but does help control one's life</td>
</tr>
<tr>
<td><strong>ATTEMPTING SELF-HARM AND SUICIDE</strong></td>
</tr>
<tr>
<td><strong>BAD EXPERIENCES WITH INTIMATE ADULT RELATIONSHIPS</strong></td>
</tr>
<tr>
<td>ambiguous experiences</td>
</tr>
<tr>
<td>attributing adult abuse to child abuse</td>
</tr>
<tr>
<td>blaming oneself</td>
</tr>
<tr>
<td>disclosing trauma to new partner (positive)</td>
</tr>
<tr>
<td>distorting view of relationships</td>
</tr>
<tr>
<td>ending relationship or making them leave</td>
</tr>
<tr>
<td>unable to end it or leave</td>
</tr>
<tr>
<td>not understanding; or questioning, reflecting on bad relationships</td>
</tr>
<tr>
<td>experiencing abuse, coercive control, chaos, manipulation</td>
</tr>
<tr>
<td>Feeling cautious, panic, sceptical about relationship</td>
</tr>
<tr>
<td>Gradually developing relationship, intimacy and trust (positive)</td>
</tr>
<tr>
<td>Positive experiences with intimate adult relationships (negative cases)</td>
</tr>
</tbody>
</table>

**BECOMING WHO I WAS AND WHO I AM**

- Becoming an inadequate person
- Being made an inadequate person by others
- Being given a diagnosis (label) by health care staff - positive cases
- Seeing oneself as inadequate person
- Taking responsibility for own (in)actions that keep one in a weak position

- Identifying as survivor
- Becoming a new person
- Being a valuable and stronger person today

**BEING AFFECTED STILL TODAY**

**BEING IN (AND TAKING) CONTROL AND ABLE TO CHOOSE NOW**

- Not being in control
- Not being in total control is okay (odd case)

**BEING THERE FOR ME**

- Being there for others
- Liking others not ‘always’ being there (positive) (negative case)
- Oneself not being there

**BLAMING OTHERS**

**BLAMING ONESELF**

**BODILY AND PHYSICAL EXPERIENCES**

- About head, mind and brain
- Not in the head, mind, brain

**BREATHEING, HAVING TIME AND SPACE TO LOOK AFTER ONESELF AND DEAL WITH TRAUMA**

- Breathing space calms, frees, brings relief and safety, examines, slows down
- Breathing space given by others
- Breathing space pursued by oneself
- Distracting or avoiding gives breathing space (maybe)
- Feeling anxious, alert, bulldozed when having no breathing space (negative cases)

**COMPARING AND CONTRASTING EXPERIENCES TO EVALUATE AND MAKE SENSE OF THEM**

**CONNECTING ADDICTION WITH TRAUMA AND TRAUMA RECOVERY**

- With sobriety, trauma memories come to the foreground
drinking or drugging to cope with trauma experience

**CONNECTING FOOD WITH TRAUMA**

**CONTACT WITH PROFESSIONALS AND SERVICES**

- accessing, being referred to and attending services
- feeling-related
  - feeling uncomfortable at service
  - feeling good at service
- interpersonal quality of contact
- negative experiences
  - attributed to service
  - attributed to self
- praising services
- mental shifts, and learning about trauma and oneself
  - naming it
  - effects of treatment
    - awareness, realisation
    - being challenged, confronted
    - developing strategies
    - getting it out
    - getting new information; learning
    - peer support
    - relieving emotions
    - social skills
    - negative cases (no effect)

**DEFINING RECOVERY AND HAVING A LIFE**

- defining pre-recovery and not having a life

**DENYING AND AVOIDING TO LOOK AT TRAUMA-RELATED ASPECTS AND ONESELF**

- avoiding look at what happened (abuse)
- avoiding people
- avoiding places or (non-IP) situations
- avoiding no longer works
- avoiding to look at oneself and at own problems
- avoiding uncomfortable feelings
- making sense, understanding
not avoiding relationships (negative case), create in “avoiding people
not making sense, not understanding

DISOWNING AND DISTANCING FROM ABUSERS TO FIND SAFETY AND BREATHING SPACE
confronting the abuser - negative cases
disowning the other by relabelling relationships
distancing can lead to missing out
staying away from a sick friend

DISSOCIATING (PATCHY EPISODIC MEMORY)
DISTRACTING ONESelf FROM TRAUMA AND DISTRESS TO FEEL BETTER AND FEEL CALM (ALTERNATIVES)
mistaking distraction as avoidance

DOING OR EXPERIENCING SOMETHING HELPFUL DESPITE IT BEING CHALLENGING
EXPERIENCING FLASHBACKS (NIGHTMARES)

attempting to manage flashbacks
by avoiding, drowning, distracting from it
by bearing it, going through the motion
by learning grounding techniques
by rationalising flashbacks
rationalising it is not working (negative cases)

with the help of others
experiencing flashbacks of ...
explaining, exploring, differentiating, mistaking, thinking about flashback to makes sense of them
finding words for flashback experiences
identifying and receiving support with flashbacks in conversations with others
not having known before what a flashback is

EXTERNAL FACTORS
being financially exploited, having debts, clearing debts
moving away, or moving around

FEELINGS
feeling anger (and jealousy)
feeling shame and guilt
negative cases (not ashamed)
feeling uncomfortable when saying no
feeling down or tension near person who harmed me before
feeling frustrated when trying to communicate experiences
feeling scared to be abandoned or rejected by others
negative cases
feeling uncomfortable with people in general
finding it difficult to do recovery
remembering feelings of trauma incidents
feeling confused, disconnected, disoriented after flashbacks
experiencing positive feelings with people and services today
feeling grateful today
feeling joy and excitement today
feeling confused, frustrated, numb and inhibited generally
feeling panic and anxiety (generally or specifically)

FINDING WORDS FOR DESCRIBING TRAUMA AND RECOVERY JOURNEY

using the term 'DEALING WITH'
being explained
calling trauma, abuse etc. for what it is
difficult to explain
using analogies to communicate
using trauma-specific terms

FORGIVING ONESELF, OTHERS, AND WHAT HAPPENED

FORWARD-BACKWARD-FORWARD MOVEMENTS

GOALS AND ACTIVISM

HOPE
false hope

IDENTIFYING WITH OTHERS
identifying with others brings hope, freedom, relief
negative cases

INTERNAL PROCESSING OF TRAUMA
processing interpersonal aspects (unclear)
I don't know. Don't understand.
Identifying needs (unclear)
knowing, being aware and being certain about something (unclear)

ISOLATING, BEING ON MY OWN
feeling less alone, not isolating when with others (negative cases)
| **wanting to be alone (odd cases)** |
| **JUSTIFYING OR EXCUSING OTHERS LACK OF TIME OR CARE** |
| **LIGHTBULB MOMENTS, TURNING POINTS** |
| **LIVING LIVE TODAY** |
| **LOOKING AT ABUSE AND TRAUMA EXPERIENCES AND ONESELF TO MAKE SENSE** |
| odd cases (not looking) |
| looking at experiences by oneself |
| looking at experience alone is distressing (negative cases) |
| looking at experiences with the help of others |
| **MAKING ASSUMPTIONS ABOUT TRAUMA AND RECOVERY** |
| **MAKING SENSE OF AND MANAGING FEELINGS** |
| attempting to manage feelings |
| comparing, differentiating, contextualising feelings |
| not processing, or mismanaging feelings - negative cases |
| avoiding, numbing or doing nothing about feelings |
| destroying oneself emotionally, taking risks |
| doing it alone not working |
| **MAKING THE INVISIBLE (INTERNAL) VISIBLE (EXTERNAL)** |
| negative cases (making an experience invisible) |
| **MEMORIES AND REMEMBERING** |
| flashback memories and other unpleasant memories |
| active remembering |
| Forgetting |
| being vague; generalising |
| **NEGATIVE EXPERIENCES WITH PEOPLE** |
| actively contributing to having negative experiences with others |
| allowing others to treat me bad, being too nice |
| pretending everything is fine when it isn’t |
| negative cases |
| unrealistic perceptions of or with people |
| avoiding getting close to people generally |
| naming characteristics of those who harmed them (adjectives refer to action) |
| adjectives for the other or circumstance |
| stories and actions of others or circumstances |
### Making the invisible visible: A grounded theory study...

#### Appendices

<table>
<thead>
<tr>
<th>Negative Cases</th>
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<tr>
<td>Naming what happened to them (the abuse, passive voice)</td>
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<td>Naming what happened in childhood</td>
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<tr>
<td>Naming what happened as adult</td>
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</tbody>
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#### NOT HAVING KNOWN BEFORE WHAT TRAUMA AND BEING TRAUMATISED IS

#### Receiving Support from Friends and Family

- Being able to talk with friends + family without being judged harshly
- Being comforted, validated, protected, understood by friends + family
- Friends and family being actively involved
- Receiving guidance - being shown or advised by friends + family what to do

#### Resisting, Being Challenged, Being Stuck with Understanding What's Going On

#### Saying No

- Saying yes or saying nothing leads to exploitation
- Saying no feels uncomfortable, has repercussions

#### Seeing Trauma Experiences, People, Myself, the World Etc. Differently Now

#### Set Aside

#### Speaking Negatively About Someone

#### Spiritual Beliefs

#### Survivors' Experiences as Parent

#### Taking Risks for Attention and Care

#### Talking About It, Talking with Someone

- Not talking or not having talked about trauma and abuse (negative cases)
- Because environment discouraged or ignored talk of trauma and abuse
- Feeling uncomfortable, crazy, isolated, unlocked when talking about trauma
- Finding it hard to talk about it to someone

#### Outcomes of Talking about it to Someone

#### Talking about trauma and recovery (to others)

- To get it out

#### Talking to oneself

#### Talking with others (generally)

#### Negative cases (not talking with others)

#### Thinking Not Logically

#### Tool Box (Behavioural, Practical, External Aspects)
developing ways to cope (generally) and finding this simple, hard, silly, sceptical, airy fairy
doing art
doing EMDR looks at, gains control and distance from trauma memories
doing meditation, mindfulness, yoga
exercising and eating well to feel well, distract from stress, and think clearer
knitting to do and achieve something
learning to relate to others, generally
listening to music
reading and watching videos about trauma, abuse, the brain, coping strategies
taking pictures
tracing back, linking past to present

effects of tracing back - understanding, demystifying
negative cases (looking forward)

using affirmations
walking outside to fill the day and sleep
writing
having no or dysfunctional strategies to cope (negative cases)

DISTRUSTING OTHERS
being cautious or ambiguous about trusting
testing out if someone can be trusted and gradually building up trust

USING HUMOUR FOR ATTENTION AND CARE (OR DISTRACTION)

VALIDATION, ACCEPTANCE, RECOGNITION, IDENTIFICATION

general validation
trauma-specific
Appendix O: Mapping of refined categories and sub-categories and their relationships (theoretical coding)

(Left part)
Appendix O: Mind map of refined categories and sub-categories and their relationships (theoretical coding)

(middle part)
Appendix O: Mind map of refined categories and sub-categories and their relationships (theoretical coding)
Appendix P: Memo of theory development

27.10.2016

I feel stuck. I’ve been writing about my results now for several weeks. My diagrams keep changing. Every time I write another rough draft (without including literature – which is actually what I’m supposed to do: include literature) I come to a new insight – which is good – but changing how I view my data prevents me from including literature. The good thing is, though, that I start getting a feeling of moving from a more descriptive level to a more analytic level. Maybe.

Model 1 – four theoretical categories of equal weight and unspecified interactions

In order to not lose track in what way these diagrams change, I’ll try to do a recap here: At first I started describing and explaining some key NVivo-based categories, for example, “finding words…” and “talking about it”. I added example quotes to it and a little bit of literature. I did not finish the whole process at this point because there were too many key NVivo categories. I knew, however, at this point that these categories could be summarised under 4 ‘theoretical categories’ (themes?): (1) survivors labelling and expressing their trauma and recovery experience to ‘get it out’ and make sense of it, (2) survivors are like scientists, questioning, researching, comparing, contrasting, explaining, testing … also to make sense of it, perhaps to change one’s life and to gain control, (3) survivors reshape or reconstruct their self from, at first, perceiving oneself as faulty, bad, mad, stupid and without value to, then, perceiving oneself as stronger and valuable ‘me’, and (4) survivors seeking/receiving support and forming social bonds. The diagram looked like this:
If I had continued describing and explaining each main NVivo category (about 5 or more each) for each of these 4 theoretical categories (that is, each NVivo category had included a description with quotes, then an explanation of causes and consequences, of links to the other 3 theoretical categories, and of emotional and interpersonal aspects) then I would have easily ended up with a 40,000-word document!

**Supervision feedback in October**

I was advised at this point that this would be too repetitive and too descriptive. I should aim to move to a more analytic level (What does that look like with my data?), and consider explaining each theoretical category briefly as a whole (less focus on the allocated NVivo-based categories) and their interactions. I was also advised to label the arrows in order to identify processes between these 4 theoretical categories. The question of who is the actor or agent came up. That is, are the
survivors actively seeking help, or finding words or someone to talk to etc.; or are other people offering help, or provide labels or offer to listen and explain?

**Model 2 – processes added, two aspects merging, two other aspects identify different actors**

This is what I attempted to change. I produced another rough draft (without literature; just spitting it out) of about 3,700 words. In this draft I summarised each of the 4 theoretical categories (separately without their links; but slightly dividing it into the survivor being the actor/agent and ‘the others’ being the agents/actors) in only about 300 words each; then I focused on the links, describing/explaining each possible direction (12 in total). While doing so I noticed that 2 theoretical categories started moving closer together as they included similar processes, both influencing the other 2 theoretical categories in a similar way. That is, ‘labelling/expressing one’s experience’ and ‘the survivor as scientist’ both help to reconstruct, make difficulties visible, and make sense of trauma. While the survivor can make use of both of these aspects (labelling/expressing and investigating) by herself without the help of others, and while this can be successful to a certain degree, this does not seem to be not enough to heal. Because perhaps of the survivor’s fear, shame and not feeling safe enough or comforting themselves enough (self-talk) etc. this might hold them back to challenge their situation and themselves and to move far enough out of their comfort zone but still remaining somewhat safe. There are still too many factors that keep them stuck. But there seems to be a point [this ‘point’ needs more explanation, description] when isolation doesn’t bring further solutions, or when suffering by oneself and being stuck reaches a tipping point, and then survivors seek help – or another person in their immediate environment notices that they are not okay and reaches out. And then both parties use similar strategies: labelling/expressing and investigating in order to make it visible, reconstruct survivors’ experience together and to make sense of it. Visually, this might look like this:
Model 2 (adjusted) – ‘shared responsibility’ and inner & outer circle added

While the diagram started changing, the process/idea(?) of sharing responsibility as part of the recovery process emerged. Survivors often report blaming themselves for what happened in the past and blaming themselves also for their present struggles. They feel responsible for both and this may create so much distress that it inhibits them to make any changes (evidence may be found in large reports of them feeling confused, frustrated, numb and anxious etc. which may prevent them acting).

Because they also often report that they did not know before that what happened to them in the past is not normal, but abuse, and that the difficulties they experience today are not about them being mad, but are a normal response to traumatic events (like abuse), I assume that they did not – could not – assign any responsibility to their
abuser. An abuser outside themselves did not exist in their understanding. But when others around them start explaining that their experience is abuse and trauma, the responsibility for the past event is lifted off the survivor’s shoulder (so to speak) and now assigned to their abuser. And I think this becomes visible in survivors often blaming the people who harmed or did not protect them. Part of the double responsibility becomes shared, and other people help the survivors to do so. But not only do they help the survivor – through reconstructing survivor’s narrative – to re-assign responsibility for the abuse to an abuser, they also take a share in carrying the survivor’s responsibility for recovery today by reaching out, by listening, by believing survivors’ story, by actively getting involved, but also providing a safe breathing space. These professionals, friends, peers, family members could choose not to do all this (and where sometimes they didn’t, survivors report feeling let down), but by ‘being there’ for survivors in these ways (that is, by reaching out, explaining, listening, believing, questioning, providing comfort and safety etc.), for the survivor responsibility for recovery becomes shared. Placing this in the previous diagram (here simplified), it might look like this:
I started looking for literature that talks about sharing responsibility and shifting blame as part of treatment/recovery in the way I describe it above. Most of this talks about shared responsibility between client and therapist with regards to treatment progress and outcome, but not about shifting/sharing responsibility as part of reconstructing the narrative. But maybe there are other terms (maybe unknown to me) for what I describe which results in not finding anything? What I did find, however, was literature on cultural traumas and solidarity – trauma as a social theory (e.g., Jeffrey Alexander, http://the.sagepub.com/content/132/1/3.short?rss=1&ssource=mfr). And some of the ideas around that might relate well to my model – from macro level (cultural trauma and recovery) to micro level (individual trauma and recovery). With this larger social dimension in mind, I started to expand by model further from two circles to several circles.

**Model 2 (extended) – wider social and cultural dimensions of abuse and trauma**

While the inner circle represents what the individual survivor does to heal, the next circle represents those people who most of my participants report to have been in contact with: health professionals (GPs, CPNs, counsellors/therapists, trauma specialists), recovering peer survivors, and supportive friends, family members (though, rare) or neighbours. A third ring includes wider society, perhaps institutions, media, politicians, police, schools/colleges/universities who might have the power [redistributing power?] to share responsibility for trauma survivors’ recovery. And finally, an outer ring might show the culture and era that might influence trauma survivors’ recovery and that might set the larger scene of what is perceived as shared or not shared responsibility for abuse and interpersonal trauma (such as, perhaps, women and children being socialised into accepting interpersonal violence as normal, or the feminist and human rights movement fighting against this socialisation process?). I think in all these circles, the actors apply similar activities in order to make visible (or keep hiding), to reconstruct (or maintain), to make sense of (or confuse and distort), and to gain control over (or ignore or enable)
abuse and trauma. That is, in all these circles the actors label and express their experience/knowledge about abuse and trauma; they question, they explain, they compare and contrast experiences/knowledge, they test out, investigate, challenge, give space to listen/talk/breath/examine, or get actively involved to support [This sounds very general at this point!]

The survivor seems to experience pressure from outer circles (1) to keep their experience of abuse and trauma inside, to keep it hidden, (2) to keep the same frame of reference and stick to the same narrative (i.e., that it’s the survivor’s fault, that abuse is okay and deserved, and that the survivor’s distress about it is them just being mad), and to stay passive, and (3) to keep the responsibility with the survivor. In reverse, survivors’ recovery would be enhanced when actors at all circles (1) talk about abuse and trauma, (2) reconstruct or reframe abuse as not the victim’s fault, as not okay and deserved, and reframe the resulting day-to-day difficulties as normal response to traumatic events, and (3) take their share of responsibility for abuse and trauma in society. In yet another model (I know!), this might look like this:
I have seen similar circular models before (e.g., Dahlgren & Whitehead (1991). Policies and strategies to promote social equity in health). I think it’s good that I have constructed this current model in a similar diagram, but *without having set out* to put it into this shape. I have only remembered similar models *after* coming up with this one from my own data. While this circular form is not new, this one here is new-ish because it applies particularly to abuse and trauma recovery.

**Reviewing supervision tasks**

Coming back to the tasks suggested in previous supervision, to what extent have I addressed them? I think what I present in figure 3 and 4 (and 2 to some extent) starts looking more analytical. I have also labelled arrows now to show processes, in particular related to diagram 2 and 4. And I have identified actors and recipients of actions.

I have also previously written a draft describing and explaining the initial 4 theoretical categories and their interactions (the 3,700-word piece mentioned earlier). However, with the subsequent model developments, the way I presented it seems too separate, like describing individual islands in a large ocean. And it does not include quotes and literature to support it. It requires a narrative that connects them more fluently.

**Outline of next draft**

My current idea – in terms of writing up yet another piece of analysis – is to, perhaps, start out by only describing the individual survivor first: their current traumatic life (e.g., dealing with a tone of confusing emotions, being isolated and suicidal, saying yes too much and then being exploited, harmful intimate relationships etc.), what they do to address their problems by themselves without help from outside (e.g., writing in a journal and reading about trauma which helps relabel and reconstruct one’s experience, questioning/confronting themselves and
their life, going running or distancing oneself from toxic people to gain personal breathing space), and to what extent these activities seem to improve their life or maintain their problems (or make them worse). Quotes from my data and literature need to be added here.

Because healing from trauma cannot occur in isolation – as I argued earlier –, at this point I can draw a link to the next circle where health professionals, peers and supportive family, friends or neighbours are either sought out for support by the individual survivor, or offer support. I can write about what activities survivors do to get another person’s support, and what other people do to give support to the survivor (to address the issue of agency). Most of these activities will related to labelling/expressing and investigating, which seem to result in making trauma/abuse visible, reconstruct the survivor’s story, make sense of what happened and what is happening, and gaining control over one’s life. And after explaining this collaboration between the inner circle and the next outer circle, I can develop the idea/process of sharing responsibility. Again, I need to support this with quotes and literature.

Because I’m coming from a psychological (rather than sociological) angle, I guess my main analysis of trauma recovery stops here. However, it might be useful to sketch an outline of how trauma recovery on the micro level can be extended to a macro level (related to the 2 outer circles in figure 4).

**But how is behavioural change in survivors achieved?**
A question regarding this analysis continues to bug me: **How is behavioural change in survivors achieved?** Most of my explanation seems to focus on cognitive change (reconstructing, making visible, understanding) with a strong social aspect (interacting with others). But are these cognitive and social aspects impact on the survivor in such a way that they can make visible changes to their lives? For example, does my current model explain how they improve their own parenting
style, or how they start having better intimate relationships, or how they make friends and solve conflicts better, or how they gain employability and financial stability, or can manage stressful life situations better, or seek safe as well as enjoyable activities? On the one hand, I think perhaps this focus on cognitive and social aspects is part of where most of my survivors are: they first need to reframe their life experience with the help of others and, by doing so, they begin to identify dysfunctional behaviour and begin to consider behavioural alternatives, but perhaps are not ready yet or are only in the early stages of making behavioural changes. Therefore, this focus on cognitive and social aspects may be due to my selected population. On the other hand, perhaps some behavioural changes have been reported by my participants and I just need to make them more visible. I want to consider behavioural changes a bit more in my write up.