

**The unique, evolving journey of recovery:  
Clinicians' perceptions of recovery in child sexual abuse.**

**A Grounded Theory Study.**

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**Doctorate in Clinical Psychology**

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## 1 ABSTRACT

**Aim:** Research suggests that impact of childhood sexual abuse can be influenced by individual coping styles, attachment and environmental factors (Runtz & Schallow, 1997; Banyard, 2003). Consequently the nature of recovery amongst children and young people may vary considerably. Recent years have seen research focus on resilience and recovery. However, there remains debate as to definitions of recovery, efficacy of treatment interventions and validity of current theoretical models. As a result, research literature has yet to provide a unified developmental model of recovery following sexual abuse. This study therefore aimed to explore the meaning of recovery to clinicians currently working within child sexual abuse services.

**Method:** In-depth interviews were carried out with twelve clinicians working within three child sexual abuse teams and were analysed using a constructivist Grounded Theory methodology (Charmaz, 2006).

**Results:** Within this study clinicians perceived recovery from sexual abuse as a unique, evolving journey which was likely to continue across the lifespan. This journey involved returning to and moving through natural phases of growth and learning which had been interrupted or distorted through abusive experiences. Five distinct phases of recovery emerged; building safety and trust, integrating the experience, building familial relationships, finding self-worth and re-engaging with the world. Clinicians' described a uniquely developmentally sensitive view of recovery in which the significance of family relationships upon recovery was emphasised. Specific concerns around stigma and language use also emerged.

**Discussion:** The findings from this study were discussed in the context of existing research literature in order that the implications for theory and clinical practice could be considered. A methodological critique was also provided.

## 2 THESIS RATIONALE

This study aimed to further understanding of the meaning of recovery from childhood sexual abuse as viewed by clinicians currently working within this field. It therefore sought to highlight the characteristic aspects of recovery as seen within clinical practice. The qualitative methodology of constructivist Grounded Theory (Charmaz, 2006) was selected to match these research aims as it is an inductive approach which allows generation of theory from raw material gathered.

### *Why explore recovery from child sexual abuse?*

As part of my chosen elective within the Child Sexual Abuse Service I attended frequent multidisciplinary meetings and had the opportunity to shadow clinicians working within the team. Alongside this, I was acquiring knowledge about the nature and impact of child sexual abuse through reading relevant literature about theory and frameworks for clinical practice. Reflecting on material presented at a conference for adult survivors of sexual abuse, it appeared that the focus of language centred on recovery and this differed from that which I heard within child and adolescent services. In discussing these observations with team members, they acknowledged the prominence of the 'recovery concept' in adult work however they expressed hesitancy with use of the term 'recovery' when working with children and young people. Looking deeper, research literature regarding adult survivors has moved from purely documenting the prevalence and negative impacts of childhood sexual abuse to exploring factors which may impact upon recovery (Banyard & Williams, 2007). However, although treatment approaches are commonly reviewed, the actual form or meaning of recovery as seen within children and young people has been explored less frequently and receives minimal mention within documentation released by government health agencies (Scottish Executive, 2002). Historically, there has been a tendency to define recovery in negative terms, for example the reduction of unwanted symptoms such as flashbacks, dissociation or externalizing behaviours such as substance misuse (Briggs & Joyce 1997, Hutchison, 2007, McCauley et al, 1997). However, more recently resilience has entered the recovery field.

Jones and Morris (2007) propose that child sexual abuse could be viewed as a '*collection of relationships and abusive experiences*' which constitute a systemic problem (p.224). As such multiple levels of intervention may be required with therapies offered across developmental life stages and involving more than the survivor in isolation. However, a variety of theoretical models have been provided to describe the impacts of child sexual abuse and there exists considerable variation between these (Banyard and Williams, 2007). In addition, there remains considerable debate as to the efficacy of treatment interventions currently provided (Skowron & Reinemann, 2005).

In conclusion, there has been minimal consideration of the concept of the nature of recovery during childhood following sexual abuse. The diversity of theoretical models, approaches and factors that impact on adjustment suggests that a complex process of integration may be required to provide the individualised treatment necessary. However, there has been less frequent exploration of the meaning of recovery to clinicians currently working within child sexual abuse teams. This study therefore seeks to increase understanding of clinicians' perceptions of recovery.

### 3 INTRODUCTION

The purpose of this introductory chapter is to further clarify the rationale for the current study by reflecting upon relevant literature. The first section (3.1) discusses the growing interest regarding recovery within mental health and the varied meanings which it has been ascribed. The second section (3.2) then explores the increasing prominence of recovery within the area of child sexual abuse. The third section (3.3) explores the impacts of child sexual abuse. The factors which can affect recovery from sexual abuse are then outlined in the fourth section (3.4). In the fifth section (3.5) conceptual models of child sexual abuse are described and the following section (3.6) outlines evidence based practice for treatment interventions. In the final section the aims of the current study are outlined (3.7).

#### **3.1 Recovery in mental health - historical and political context**

*'Recovery is variously described as something that individuals experience, that services promote, and that systems facilitate, yet the specifics of exactly what is to be experienced, promoted, or facilitated - and how - are often not well understood either by the consumers who are expected to recover or by the professionals and policy makers who are expected to help them.'* (Jacobson & Greenley, 2001, p.482)

The concept of recovery has taken an increasingly prominent place within the sphere of mental health. Growth of research in this area has been influenced in part by researchers and policy makers listening to the views and experiences of service users and their desire to move away from potentially stigmatising illness and disability models of mental health (Scottish Recovery Network, 2008). These developments have seen national and international mental health reforms which claim to signal the reshaping of services towards an ethos of recovery.

Within the UK this has been reflected in the key areas of priority outlined in the *National Programme for Improving Mental Health and Wellbeing* (Scottish Executive, 2001) which include promotion of and support for recovery from mental health problems. A commitment to promote social inclusion and reduce stigma within mental health services has also been demonstrated with publications such as *Realising Recovery: A National Framework for Learning and Training in Recovery*

*Focused Practice* (NHS Education for Scotland and Scottish Recovery Network, 2007). Similar commitments to raising the profile of recovery have been outlined in the United States with the publication of *Achieving the Promise: Transforming Mental Health Care in America* (Department of Health and Human Services, 2003).

Despite these advances, Davidson *et al.*, (2005) highlight that there remains some confusion as to the meaning and practical implications of adopting a recovery focused model within arenas such as mental health systems. They attribute this confusion in part to the fact that literature regarding recovery has originated from two differing viewpoints. The first equates recovery with freedom from symptoms. This conceptualisation of recovery appears to have been generated from longitudinal outcome studies exploring trajectories of serious mental health problems (Carpenter & Kirkpatrick, 1988). Within this context the definition of recovery refers to the amelioration of symptoms or difficulties to the extent that the individual can function adequately within their daily life.

In contrast, a second view of recovery has developed influenced by the survivor movement within mental health. This view describes recovery in spite of symptoms proposing that:

*'Recovery from long-term mental health problems is about much more than the mere absence of symptoms. It is not about being 'fixed' or back to 'normal'. It is about having the chance to live a satisfying and fulfilling life as defined by the individual, with or without symptoms'.* (Scottish Recovery Network website, 2008)

This view regards both symptoms and their causes (such as mental ill-health) as an integral aspect of that individual (Scottish Recovery Network, 2008). Recovery from this viewpoint relates to the process of overcoming the negative impacts that may be associated with mental ill-health. These include stigmatization, loss of social roles and loss of identity. It promotes empowerment of the individual to develop quality of life through increased choice and regaining a sense of control and ownership of their own future.

Davidson *et al.*, (2005) suggest that these two views are often referred to interchangeably which has resulted in both researchers and practitioners holding varied interpretations of the meaning of recovery. This consequently affects the nature of what ‘recovery orientation’ represents within services. Further complications exist with differing conceptualisations of recovery emerging dependent on the characteristics of populations studied. Davidson *et al.*, (2005) propose that differing recovery trajectories exist for physical illness, addictions, trauma and mental health. This suggestion further highlights the complexities of providing health care and support services which are genuinely recovery focused. Within the context of the current study this prompts the exploration of the trajectory of recovery specific to child sexual abuse.

### **3.2 Recovery within child sexual abuse**

Investigation of the literature suggests that the concept of recovery has been receiving increasing attention within the field of child sexual abuse. Research has moved from purely documenting the prevalence and negative impacts of abuse to exploring factors which mediate recovery (Banyard & Williams, 2007). At a service level, increased provision has been seen from voluntary agencies (Barnardo’s, 2008) and the formation of independent agencies such as Sexual Abuse Child Consultancy Service (SACCS) has occurred. However, there has also been a broadening of adult survivor led networks and support systems such as The National Association for People Abused in Childhood (NAPAC, 2008) and Survivor Scotland (Scottish Government, 2008). Research exploring the experiences of adult survivors has led to an increased awareness of the negative impact of stigma (Nelson, 2001) and has led to the release of government documents which emphasise empowerment of the individual to lead their own recovery:

*‘Survivors have generally not felt they have any power or control in their lives and many consequently have low self-esteem. Survivors have the right to be treated with respect and dignity, and to feel that they are worthy of this. This means respecting the choices survivors want to make about their recovery’* (Nelson & Hampson, 2008, p.38)

The increased prominence of recovery as a concept within adult services has been reflected in the establishment of networks and support systems which have been informed by the experiences of adult survivors of sexual abuse such as the Scottish Recovery Network (2008).

Critical incidents involving childhood abuse or neglect have led to increased audit and inquiry within health and social care services regarding prevention, identification and treatment of abuse and neglect (Scottish Executive, 2002; ). Proposals regarding how to enhance protection of vulnerable children and young people through multi-agency cooperation have also been published (Scottish Executive, 2007). However, it is notable that within such documentation there has been an absence (Scottish Executive, 2002) or minimal mention (Scottish Executive, 2005) of recovery as a concept. It would therefore seem valuable to explore the way in which individuals who work within child and adolescent services conceptualise recovery.

### **3.3 Impact of child sexual abuse on developing children and adolescents**

In 2003 the Department of Health released a document entitled *Safeguarding children: What to do if you are worried a child is being abused* (Department of Health, 2003). This document specified that the definition of sexual abuse could encompass physical contact including penetrative or non-penetrative acts, non-contact activities which involve children watching or being involved in production of pornographic material or watching sexual activities of others.

Exploring the nature and form of recovery following child sexual abuse requires firstly an appreciation of the impact which these experiences can have upon the individual. An outline of these impacts will therefore now be provided.

#### ***3.3.1 Effects in childhood***

Characteristic problems associated with experience of sexual abuse in preschool children include anxiety, post traumatic stress reactions, internalizing and externalizing behaviours, inappropriate sexual behaviour and regressive behaviour such as enuresis, encopresis and tantrums (Kendall-Tackett *et al.*, 1993). A larger number of studies have focused on impact of abuse from middle childhood through

adolescence (Tyler, 2002). Across these studies childhood sexual abuse has been associated with intra-psychic problems such as loneliness, anxiety, depression and low self-esteem (Garnefski & Arends, 1998). It has also been linked to increased vulnerability to suicidality (Bayatpour *et al.*, 1992), post traumatic stress disorder (Wolfe *et al.*, 1994), substance misuse (Watts & Ellis, 1993) and externalising behaviours such as aggression and gang membership (Thompson & Braaten-Antrim, 1998) and sexual risk taking (Boyer and Fine, 1992). Sexual abuse during childhood has also been associated with deterioration in educational performance and the presence of interpersonal and relational problems in children (Zelkowitz *et al.*, 2001).

More recently studies have broadened to consider the effects of sexual abuse on psychophysiological reactivity and neurobiological systems. This research has included prospective, longitudinal studies which have identified detrimental impacts on the sympathetic nervous system and the immune system (Putnam & Trickett, 1997).

Neuropsychological research has emphasised that the brain develops in an adaptive and 'user-dependent' way (Perry, 2005). A child brought up in unpredictable environments of persistent threat and fear may function in a state of hyper-vigilance and hyper-arousal so as to be primed to respond to threat. However, this hyper-arousal may reduce the child's capacity to process more complex information, relying instead on their innate reactive responses (Perry, 2005). Functioning within fearful environments may also stunt natural curiosity and consequently reduce positive learning opportunities. Experience of sustained abuse which is inescapable can also trigger dissociative responses which can occur unconsciously, in which bodily systems shut down in an effort to protect the self from unavoidable trauma. This process involves both biological changes such as lowered heart rate and psychological changes which include feelings of disengagement with reality (Perry, 2005). This research suggests that recovery from sustained abuse may necessarily be a long process requiring gradual shifts to coping styles underpinned by fundamental neuropsychological processes. Longer term impacts will now be considered.

### 3.3.2 *Longer term effects of child sexual abuse*

There is now substantial empirical evidence that experience of childhood sexual abuse can increase vulnerability to mental health problems in adulthood (Briere, 1992; Ramchandani & Jones, 2003; Spataro *et al.*, 2004). These traumatic experiences have been associated with intra-psychic problems such as low self esteem (McCauley *et al.*, 1997) depression (Spataro *et al.*, 2004), anxiety (Ramchandani & Jones, 2003), post traumatic stress disorder (Courtois, 1996) and with specific forms of eating disorder such as bulimia (Redford, 2001). Associations have also been found with higher rates of substance misuse and self harm (Roesler & Dafler, 1994). Childhood trauma can also increase vulnerability to development of psychotic disorders (Bendall *et al.*, 2008) and borderline personality disorder which may be mediated by factors such as cognitive distortions, maladaptive schemas and psychological distress (Lynn, 2004; Katerndahl, Burge & Kellogg, 2005).

Abuse experiences in childhood have also been linked to later interpersonal difficulties which can manifest in sexual dysfunction and problems within intimate relationships (Dent-Brown, 1993). A variety of trans-generational impacts of abuse have also been documented. These include increased rates of punitive parenting (Roberts *et al.*, 2004) and attachment difficulties in parents who themselves have experienced abuse (Douglas, 2000).

Consideration of this research across both child and adult populations highlights the variability in responses to abuse. However, Spaccarelli (1994) also highlights that a significant percentage of children will remain asymptomatic following abuse. Although this may reflect methodological problems of the research or suppression of distress which may surface at a later stage (Kendall-Tackett *et al.*, 1993), it also suggests that experience of sexual abuse alone cannot be assumed to predict subsequent difficulties. Indeed, individual accounts have further validated the unique nature of individual responses (Banyard & Williams, 2007). It is now widely accepted that no singular syndrome or precise constellation of responses can be ascribed to those who have experienced childhood sexual abuse (Beichtman *et al.*, 1991; Kendall-Tackett *et al.*, 1993). As noted by one researcher '*childhood sexual*

*abuse is a complex life experience, not a diagnosis or a disorder'* (Putnam, 2003, p.269). It is therefore necessary to explore what factors might mediate the impact of sexual abuse and subsequent recovery.

### **3.4 Factors which influence recovery from sexual abuse**

Banyard (2003) states that it is important to understand the factors which influence the impact of sexual abuse since this may help clinicians to identify areas for intervention. Merrill *et al.*, (2001) described such studies as third generation, since they go beyond purely describing the prevalence and negative impacts of abuse.

#### ***3.4.1 Nature of the abuse and the environment***

Research suggests that the nature of the abuse itself, such as the child's relation to the perpetrator and reactions of family to the abuse, may have a significant impact upon recovery. However, this research has yielded inconsistent results. For example a number of studies have failed to demonstrate a clear link between nature of abuse, age of onset and poorer outcomes for the child (Calam *et al.*, 1998; Mennen, 1995; Tebbutt *et al.*, 1997). However, Mian *et al.*, (1996) found that repeated and more severe abuse was related to more negative impacts. Increased severity of abuse has also been associated with higher levels of post traumatic symptomatology (Boney-McCoy & Finkelhor, 1995). In addition, abuse which includes threats, violence, or invasive or penetrative sexual acts appears to have more negative effects (Beitchman *et al.*, 1991; Draucker & Martsolf, 2006). As regards the identity of perpetrator, intra-familial abuse has also been associated with increased rates of anxiety and depression in comparison to extra familial abuse (Tremblay *et al.*, 1999). Those abused by multiple perpetrators have also been found to have increased psychiatric diagnoses (Gray *et al.*, 1999). The secondary impacts of abuse such as break down of the family, negative reactions to disclosure (Adams-Tucker, 1982) and participation in lengthy investigations of abuse through court systems (Everson *et al.*, 1991) have also been associated with poorer outcomes.

Conversely, protective factors have also been identified which may ameliorate the negative impacts of abuse. For example, Chandy *et al.*, (1996) found that paternal

concern was associated with less negative outcomes for boys, whilst emotional attachment to family was found to be protective for girls. Support from family and peers has also been associated with reduced externalising difficulties and more positive self worth (Tremblay *et al.*, 1999). Given the positive influence which such relational factors have upon recovery from abuse, it would therefore seem important to explore the mechanisms underlying these attachments and the reasons for their protective function.

### **3.4.2 Attachment**

Abuse in childhood can have devastating impacts since this is a crucial time at which fundamental psychological processes occur that lay the foundations upon which later experiences are built (Herman, 1992). These include formation of beliefs about the intrinsic worth of the self and others during the development of individuated identity and attachment to care givers (Bowlby, 1977). Consideration of attachment theory (Bowlby, 1977) is valuable whilst attempting to understand the intra-psychic and interpersonal difficulties faced by those recovering from childhood abuse (Alexander, 1992).

Within this model, attachment behaviour, which includes seeking proximity to and relationship with key caregivers, is considered to be an innate protective survival function (Bowlby, 1977). Early experiences with attachment figures influence the creation of a mental representation known as an internal working model on which an individual's character and identity is built. Functioning within an abusive environment can result in development of an internalised view of the self as unworthy, incapable and unlovable and an internal representation of the other as untrustworthy, uncaring and abusive (Herman, 1992). Alexander (1992) suggests that the three forms of attachment most commonly associated with abusive childhood experiences are resistant, avoidant and disorganised attachments. It would therefore seem that attempts to facilitate recovery may require understanding and working with the effects of such attachment styles. Consequently, it would also seem valuable to explore the way in which clinicians currently facilitate such processes.

### **3.4.3 Cognitive appraisals**

Briere (1992) asserts that abused children will often seek to understand why they were maltreated. However, due to the dichotomous and egocentric thinking styles characteristic of a younger developmental stage they may make erroneous assumptions. For example, presumptions of the child that adult carers will know what is best for them and act accordingly, might lead them to blame themselves for the abuse. An internalized view of the self as bad or deserving of the abuse may provide the child with a temporary explanation, albeit distorted, of the acts they have experienced. However, such fundamental, self-denegratory beliefs often stay with the child into adulthood and can have devastating effects. Indeed, '*the extent of self-hatred that these dynamics can engender is often startling, as is its endurance during treatment*' (Briere, 1992, p.28). Finkelhor and Brown (1985) postulate that abuse is characterised by four 'traumagenic dynamics', namely traumatic sexualisation, stigmatization, powerlessness and betrayal. It is suggested that these destructive dynamics can distort the child's cognitive and emotional response to themselves, others and the world. Further exploration of these cognitive responses has suggested that attributions relating to self-blame have been associated with greater symptomatology following abuse, whilst cognitive avoidant coping strategies have also been associated with increased risk of psychological difficulties (Spaccarelli, 1994). This emerging literature indicates that intra-psychoic factors such as individual coping style may also impact on recovery following abuse.

### **3.4.4 Resilience**

As in a number of areas of mental health, interest has also turned to resilience (Liem, 1997). It has been proposed that resilience is an individual capacity to defy maladaptation following trauma or aversive experiences (Bonanno, 2004). However, an increasing number of researchers do not now view resilience as a static personal characteristic but rather conceptualise it as a multifaceted collection of responses which '*scaffold successful adaption*' (Roisman, 2005, p.264) in the face of trauma or difficulty (Van Vliet, 2008). In addition, Masten, Best, and Garnezy (1990) suggest that differing levels of resilience exist and include occasions in which individuals show initial negative consequences of trauma but over time recover adaptive

functioning. Resilience is therefore viewed by some as a dynamic set of responses and capabilities which evolve across the lifespan during differing stages of development (Luthar *et al.*, 2000).

A variety of factors have been identified which impact on resilience including positive intra-psychic and environmental processes (i.e. self esteem and productive cognitive appraisals) and good systemic supports at critical periods (Rutter, 1987). Sources of resilience in response to trauma include a maintained sense of self worth and self efficacy manifested in a belief in one's own ability to cope (Liem, 1997). It would seem possible that both these factors may be at an early and evolving stage of development within children and young people.

There has been some debate as to the differentiation between concepts of resilience and recovery. Some have suggested that recovery itself is a form of resilience since *'it emphasizes the achievement of successful adaptation following a period of maladaptation or developmental difficulty'* (Roisman, 2005, p.264). In contrast, others have argued that the two concepts are mutually exclusive. Bonnano (2004) proposes that resilience constitutes an individual's ability to maintain their equilibrium despite adversity whilst recovery describes a process in which optimal functioning that is temporarily compromised as a result of trauma, gradually resolves over time.

Conceptual debates are common and highlight the lack of a unifying conceptualisation of recovery within existing literature. Absence of a unifying theory may lead clinicians to rely on a range of current models to explain their practice.

### **3.5 Conceptual models of child sexual abuse**

A variety of models have been proposed in an effort to explain the wide ranging impacts of abuse. Given that post traumatic symptomatology is commonly experienced following sexual abuse (Rodriquez *et al.*, 1996) it is not surprising that a number of these models have been grounded within a post traumatic stress framework (Briere & Runtz, 1987; Herman, 1992). However, some have argued that these models are not sufficient to explain the diversity in responses to abuse

(Spaccarelli, 1994) and may lead clinicians to fail to meet the needs of their clients. Developmental models have also been proposed. Alexander (1992) has emphasised the role of attachment styles developed in the context of abuse and Putnam (1990) has argued that abuse can be detrimental to the child's developing sense of self.

Cognitive behavioural models of child sexual abuse have also been proposed. Hoer (1992) suggested that much of the symptomatology following child sexual abuse can be attributed to a combination of conditioned responses and behaviour based on distorted conditional assumptions about the self and others. In contrast, behavioural models have also been proposed which are built on the principle that many of the conditioned symptoms and behaviours seen post abuse take place in an effort to avoid thoughts or feelings related to the abuse (Polusny & Follette, 1995). However, these models have been criticised for their lack of consideration of the attributions and cognitions shown to mediate recovery from abuse. Feminist models, while not clinically based, have added to understanding regarding the need to address power imbalances and avoid re-enactment of abusive dynamic within therapeutic relationships (Herman, 1992).

These models constitute only a selection of those so far developed in relation to child sexual abuse. The diversity of these models highlights the lack of cohesion among theoretical frameworks. It could be argued that varied explanations given for the complex responses to abuse reflect uncertainty about these issues.

### **3.6 Evidence based practice for interventions following child sexual abuse**

Effective clinical practice is assisted by a solid theoretical research base on which to base guidelines. This is likely to have significant impacts on clinicians hoping to provide evidence based practice. Evaluation of the efficacy of psychotherapeutic interventions for those who have experienced child sexual abuse has proved problematic. This is attributable in part to the fact that co-morbid problems are commonly found amongst those who have experienced sexual abuse (Belsky, 1993). Ethical constraints have also limited the use of control groups in which treatment effects can be compared with those from whom treatment has been withheld (Finkelhor and Berliner, 1995).

Recent attempts have been made to address these problems with studies including random assignments to varying treatment conditions. A large proportion of these studies have highlighted treatment gains achieved through Cognitive Behavioural Therapy (CBT) (Cohen et al., 2000). Deblinger *et al.*, (1996) concluded that the most efficacious treatment was found to be CBT directed specifically to the child. Superior treatment effects for abuse focused CBT have been found in comparison to non-directive supportive therapy (Cohen and Mannarino, 1998) and routine supportive treatments (Celano *et al.*, 1996). Significant reduction in PTSD symptomatology specifically has also been reported as a result of cognitive behavioural interventions (King, *et al.*, 2000). Indeed, Putnam's (2003) review of outcome studies concludes that abuse-focused CBT directed to the individual child but frequently in conjunction with interventions provided for non-abusing parents are the most extensively assessed and effective treatments available. Saywitz *et al.*, (2000) conclude that outcome studies predominantly support behavioural and CBT approaches.

However, despite the prominence of CBT approaches within outcome studies, research has demonstrated that a range of therapeutic interventions are frequently offered to children who have experienced sexual abuse (Finkelhor & Berliner, 1995). These include behavioural approaches, child-centred play therapy and psychodynamic psychotherapy. There is less empirical evidence to support the efficacy of such treatments. For example, one recent evaluation of client centred play-therapy reported only moderate support for treatment efficacy with significant gains seen in children's perceptions of competency but no significant difference in other outcome areas in comparison to control groups (Scott *et al.*, 2003). However, it was noted that non-behavioural approaches such as family therapy and brief or focused psychodynamic therapies have yet to be rigorously evaluated. The authors cite that therapeutic processes like dealing with issues such as transference are difficult to standardise or manualise and therefore limit the possibility of inclusion of these approaches in randomised control trials. In addition, outcomes achieved which include intra-psyche changes and improvements to interpersonal interactions within families are more difficult to assess than the reduction of symptomatology commonly seen in other controlled trials of CBT and behaviour therapies.

Despite the prominence of cognitive behavioural strategies within outcome studies researchers have noted that clinicians may be required to employ a wider range of therapeutic approaches due to the complex needs of some children (Suffridge, 1991). The need to be aware of psychodynamic processes such as transference and counter-transference, whilst working with children has been highlighted by a number of researchers (Saywitz *et al.*, 2000). Lanyardo & Horne (1999) postulate that the '*transference relationship*' (Lanyardo & Horne, 1999, p.58) within therapy constitutes a representation of the way in which the child may interact with those they care about. Therefore anxieties or negative expectations due to previous life experiences may be transferred onto the therapist. Counter-transference refers to the therapist's own response to the child or young person's way of interacting. The nature of this '*transference relationship*' (Lanyardo & Horne, 1999, p.58) can therefore provide rich information as to the internalised representations within the child of self and others. The therapist requires to be aware of their own feelings and unconscious reactions and to distinguish these influences from those transferred by the child.

Greenwood (2002) suggests that the nature of the child's traumatic experiences following sexual abuse are such that unconscious defences may be activated during therapy to suppress any attempt to bring these memories into the conscious mind where they may be processed. These defences may therefore be played out during therapy. Children may be unable to control these responses themselves, or may be unaware of their origin. Wells *et al.*, (1995) suggest that these defences may lead the child to avoid discussion of traumatic material. However, the process of projective identification may also occur in which overwhelmingly painful or intolerable emotions or aspects of the child self are projected onto another, such as the therapist, as a means of protection. It is therefore the therapist's challenge to be aware of these defences and the underlying processes which may be causing such '*splitting*' (Lanyardo & Horne, 1999, p.61) in order to tolerate and contain the child's emotions (Greenwood, 2002).

Wells *et al.*, (1995) highlight the need for formulation of cases which are sensitive to such '*ego/object relations structures*' (Wells *et al.*, 1995, p.420) in order that the

child's sense of self is assessed and stabilised before any trauma specific work be approached. Therapeutic contact can then gradually work to reduce primitive defences which are no longer developmentally appropriate or are destructive whilst enhancing alternative defences which enable the child to tolerate their pain and distress. . However, the efficacy of such treatment strategies requires to be more fully empirically validated (Saywitz *et al.*, 2000)

One recent literature review published by the Scottish Executive (2002) which included review of current service provision, highlighted that a variety of therapeutic approaches commonly appear to be employed to assist recovery in following child sexual abuse. These included short term behavioural group work, eclectic individual and group therapeutic treatments, long-term psycho-dynamic psychotherapy and family therapy. Given the wide variety of treatment interventions currently provided within differing services it would not be surprising if clinicians held some uncertainty as to the approaches which they should employ with their clients.

### ***3.6.1 The current position***

In summary, recent years have seen an increased prominence of recovery as a concept within adult services. This has been reflected in the establishment of networks and support systems informed by the experiences of adult survivors of sexual abuse such as the Scottish Recovery Network (2008). However, despite these changes there has been an absence (Scottish Executive, 2002) or minimal mention (Scottish Executive, 2005) of recovery as a concept within governmental documentation regarding child and adolescent services. It would therefore seem valuable to explore the ways in which individuals who work within child and adolescent services currently perceive recovery.

### **3.7 Aim of this study**

The aim of this study was to explore the meaning of recovery to twelve clinicians currently working within child sexual abuse services. This was explored using the qualitative research methodology of constructivist Grounded Theory (Charmaz, 2006) to analyse individual interviews with clinicians. The rationale for use of this approach related to its inductive nature by which theory could be developed directly from interview material. As this was a minimally explored area it was not possible to test pre-defined robust hypotheses. Use of this methodology would therefore allow an understanding of the perceptions of clinicians regarding recovery to develop. It was hoped that this study might allow a new developmentally sensitive view of recovery to be considered and contrasted to current definitions of recovery commonly found within adult mental health settings.

## **4 METHOD**

This chapter describes the research methodology of this study including the design of the study, the rationale for use of Grounded Theory, participants interviewed and the procedure followed. It also outlines quality standards for conducting qualitative research and the ethical issues relating to this project.

### **4.1 Research Methodology**

#### ***4.1.1 Design***

A qualitative methodological approach was selected to match the research aims of this study. In-depth interviews were completed with clinicians who currently worked within the field of child sexual abuse. Interviews were transcribed by the researcher and analysed using a Grounded Theory methodology (Strauss & Corbin, 1998). This is a detailed and systematic method of data collection and analysis which promotes theory development. Throughout this process the researcher created a personal journal which allowed impressions and insights about the study to be recorded.

#### ***4.1.2 Development of research topic***

Clinicians from each participating team were invited to give input regarding the possible focus of this study (Appendix 3). A majority of staff expressed a preference for exploration of the topic of recovery.

#### ***4.1.3 Rationale for use of Grounded Theory***

This research project was completed as part of a doctoral training in Clinical Psychology. It is recognised that much of the evidence base upon which this discipline has been built has honoured a positivist methodological standpoint in which it is assumed that only events which can be observed or tested may claim to be founded in objective 'truth'. This standpoint also suggests the existence of a unitary reality within which human experience and behaviour can be objectively studied and understood (Ashworth, 2008). The predominance of this stance within psychological research has been reflected in the high prevalence of quantitative research

approaches in which predefined hypotheses are tested within large scale randomised controlled trails.

However, Anderson (2006) argues that one limitation of such quantitative approaches is that much of current empirical research of this nature focuses on identifying risk factors for development of specific disorders. In contrast, qualitative methodological approaches may bring an alternative perspective which allows the exploration of '*explanatory mechanisms*' (Anderson, 2006, p.330) which mediate such behaviours and facilitate the generation of theory to describe processes of change within therapy. Indeed, Fonagy (2005) has highlighted that within the heterogeneous clinical populations commonly presenting to child and adolescent services, we know '*precious little about what works for whom*' (Fonagy, 2005, p.14). Anderson (2006) argues that qualitative research approaches produce invaluable insights though their capacity to inform day to day clinical practice. Within the field of child sexual abuse there is a wealth of large scale studies to explore the prevalence and multiple impacts of abuse. However, as previously discussed, exploration of the factors which influence recovery, its underlying mechanisms and the way in which clinicians facilitate this process are in the earlier stages of exploration.

It would therefore seem valuable to explore the meaning of recovery to clinicians who currently work to promote recovery within clinical practice. Use of quantitative measures to explore such a topic would require prior assumptions to be made about this process in order to pose testable predefined hypotheses. This study sought to use inductive techniques which would allow understanding of these mechanisms to emerge through careful consideration of insights provided by experienced clinicians.

It could be queried as to why children or young people themselves were not directly interviewed about their experiences of recovery following sexual abuse. Firstly there were ethical concerns as to the timing of when such interviews could take place. For example, interviewing those who had been seen to have made some steps towards recovery may have involved contacting individuals post discharge from services which would pose ethical concerns. Such accounts would clearly provide invaluable insights into this issue, however these would also provide a singular description of

one individual's conceptualisation of the recovery process. In interviewing staff who have worked with many individuals who have experienced abuse, it was hoped that it would be possible to learn from the wide range of differing routes to recovery witnessed by clinicians. In addition, interviewing a range of professionals would allow triangulation of their differing opinions, so as to provide an enriched view of current staff perceptions of recovery.

#### ***4.1.4 Reflexive stance***

Within the original framework for Grounded Theory presented by Glaser and Strauss (1967) material gathered was thought to constitute facts and truths about a 'knowable world' which the researcher could reveal through use of rigorous and systematic techniques. The researcher was therefore viewed as a neutral and independent vehicle through which material was gathered and analysed objectively.

However, more recently this 'objectivist' (Charmaz, 2006, p.131) view of Grounded Theory has been challenged. Authors such as Charmaz (2006) have instead promoted the use of 'constructivist' (Charmaz, 2006, p.130) Grounded Theoretical approaches. This revision to Grounded Theory suggests that the researcher cannot and should not remain an independent observer of the data generated. Rather it is accepted that their perspectives, prior experiences, insight and interpretations will influence, inform and interact with the material gathered (Charmaz, 2006). It is the challenge of the researcher to remain aware of these characteristics and influences, to reflect upon them, and to be transparent in reporting them. This viewpoint therefore acknowledges that both the researcher and participant will bring personal attributions and assumptions which will impact upon the material gathered and the resulting theory created. In addition, it is recognised that contextual and temporal factors will also affect the material gathered.

Given that I was embarking on my first placement within the area of child sexual abuse whilst working on this research, it would seem likely that my own view of recovery and therapeutic approaches might evolve during the period of research. It therefore seemed appropriate to adopt a constructivist Grounded Theory approach in which the impact of my personal experience of this work could be acknowledged,

reflected upon and utilized to inform the project itself. Personal insights and experiences gained from clinical practice could therefore be used to enrich the data rather than constituting a block to objectivity. Wisdom (1968) supported the validity of this approach stating that it was wholly appropriate and expected for an interface to occur in which the clinician's analytical skills and training will impact on the way in which they view the material gathered.

#### ***4.1.5 Contextual environment of researcher***

In a similar way it is acknowledged within this study that my clinical training is likely to have impacted upon the way in which I interact with and analyse the data gathered. However, in order to maintain awareness of any such influences and ensure the systematic recording of personal thoughts I created a personal reflective journal (Appendix 11). This included reflections on the evolving research project itself and my own personal experiences of working within the field of child sexual abuse.

I was based within a local child sexual abuse team and participants in this study included members of that team. My relationship to these participants is therefore acknowledged and reflected in later discussion of interview material. In addition, it is also acknowledged that my professional role as a trainee clinical psychologist may have impacted on the responses given by participants as a result of their own attributions and assumptions regarding this discipline. Such effects were noted within my reflective journal and are also acknowledged and discussed within this study.

## **4.2 Participants**

Twelve clinicians across three multidisciplinary child sexual abuse teams were interviewed in this study. These teams were based within three differing service sectors and provided a range of interventions. The identity and exact composition of the teams included in this study have been omitted in the interests of confidentiality. The range of multidisciplinary approaches represented in the sample is reflective of the varied composition of teams included. Participants were comprised of ten female and two male clinicians. The length of experience in working within the field of child

sexual abuse ranged between one and a half and twenty-four years (mean years of experience = 9.9 years).

**Table 1: Professions of Participants**

| <b><u>Professions of Participants</u></b> | <b>Number of participants</b> |
|---|-------------------------------|
| Social Worker                             | 2                             |
| Mental Health Practitioner                | 3                             |
| Nurse Therapist                           | 2                             |
| Clinical Psychologist                     | 2                             |
| Occupational Therapist                    | 2                             |
| Counsellor                                | 1                             |

#### ***4.2.1 Inclusion and exclusion criteria***

Inclusion criteria were that staff must currently be employed to work with children or young people who had experienced sexual abuse. Clinicians working solely with children displaying sexually inappropriate behaviours or perpetrators of sexual abuse were excluded from the study. The rationale for this decision was that research suggests that recovery for the perpetrators of abuse or those who display inappropriate sexual behaviour involves resolution of qualitatively different issues (Mezey, 1996).

A theoretical sampling approach was used. Within Grounded Theory this process involves selecting participants who may enable the researcher to explicate emerging themes. It therefore does not aim to acquire a sample fully representative of a particular population nor does it seek to create a sample whose characteristics are generalisable to the wider population.

#### ***4.2.2 Recruitment of participants and informed consent***

As described, the research topic was developed in collaboration with clinicians across the three participating teams. The draft project proposal was sent to representatives from the child sexual abuse network forum. This is an interest group

which has representation from four sexual abuse teams currently working within Scotland. Information regarding the project was fed back to individual team members via email by representatives from the network team. This material included an outline of the aims and objectives of the project and the nature and structure of interviews to be completed (Appendix 4). The researcher also attended the CSA network meeting in person to describe the aims of the study and to answer any questions which potential participants might have. Clinicians were invited to raise any questions or concerns about the research. Clinicians were then invited to make contact with the researcher should they have any further questions regarding the study or should they wish to participate. Further information regarding the study was also then made available (Appendix 5).

Once contact was made the researcher explained the project aims and procedures again to the participant and a time was agreed for the interview to take place. A minimum period of 72 hours was given before completion of any interviews in order that participants could withdraw consent should they wish to do so. Informed consent was secured prior to the interview and participants also gave consent for audio-recording of this material. Interviews took place in the work base of each participant and were carried out between February and May 2008.

### **4.3 Procedure**

The following section will describe the research procedure followed during the completion of pilot interviews, data collection and the management of data collected.

#### ***4.3.1 Pilot interviews***

Pilot interviews were completed with two members of staff from a local Child and Adolescent Mental Health Service. Each of these clinicians had extensive experience of working directly with children or young people who had experience of child sexual abuse; only one clinician had previously worked within a dedicated child sexual abuse team. The purpose of these interviews was to develop and enhance the interview technique of the researcher. Interviews were therefore recorded and passed

on to the researcher's supervisor. This material was reviewed and interview style was refined following feedback.

#### **4.3.2 Data collection**

Each participant took part in one in-depth interview which lasted between 1 hour to 1 ½ hours. Interviews were opened with discussion of the following areas:

- How long have you worked within the area of child sexual abuse?
- What other work experience have you gained prior to working in this area?

These questions aimed to allow the participant to familiarise themselves with the interview format and to become accustomed to talking with the researcher. They also provided valuable demographic information as regards professional training and previous work experience. The following main theme was then introduced for discussion:

- From your experience can you describe your understanding of recovery within child sexual abuse?

The nature of intensive interviewing (Charmaz, 2006) used within this study has been described as a directed conversation (Lofland & Lofland, 1995) as it uses broad open ended questions to allow participants to discuss issues freely, drawing in factors which they view as relevant. The researcher was keen to explore the view of recovery personal to each clinician interviewed, it was therefore decided that a highly structured interview format should be avoided. However, once the main theme of recovery was introduced, exploration of the topic was facilitated through the use of probe questions such as '*can you tell me more about that?*' These were designed to explicate evolving themes and helped to generate rich descriptions. As interviews progressed new questions were introduced that referred to themes emerging from previous interviews. This introduction of further questioning was planned from the outset as part of the constant comparison technique to assist in creation and testing out of a theory regarding recovery. However, the exact nature of questioning was not predefined. As the categories outlined above emerged they were reintroduced into

subsequent interviews in order to further deepen and substantiate these concepts. This was carried out in a pair-wise fashion in which two interviews would be completed, transcribed and analysed following which emerging categories would be carried into the following two interviews.

#### ***4.3.3 Management of data***

An audio-recording of each interview was made and these were transcribed verbatim by the researcher. Any identifiable information about the participants was made anonymous during transcription. Any significant pauses were counted in seconds and this was included in transcriptions. Significant gestures or interruptions during interviews were also noted in transcripts (see Appendix 12). Audio-recordings were stored on an NHS password protected computer in order that the researcher could return to the original source data when required during analysis. The QSR NVivo 7 software package was used to manage the interview material.

#### ***4.3.4 Data analysis - Process of Grounded Theory***

Material generated in the initial two interviews was transcribed and analysed using Grounded Theory techniques (Strauss & Corbin, 1998) specifically adopting a revised 'constructivist' approach (Charmaz, 2006). Following the principles of this approach, novel or evolving themes were identified then carried forward and explored in the following two interviews. Concurrent transcription and analysis of each subsequent pair of interviews then continued. In this way, understanding of new and evolving themes was deepened and expanded upon.

#### ***4.3.5 Open coding***

Categories were formed by grouping together examples of text which shared key features with each other. The first stage of this process required open coding of interviews. This involved identifying categories and applying both conceptual and descriptive labels to the smallest units of meaning found within the transcripts. It was therefore possible for a number of codes and a number of levels of meaning to be applied to each line of transcript. The aim of this stage of analysis was to clearly break down and describe the data in detail in order to facilitate later rearrangement

and comparison of this material. This inductive process ensured that the codes and themes emerging were fully grounded in the interview material. This also reduced the risk of the researcher precluding such themes through the imposition of previously held assumptions about the data.

#### ***4.3.6 Focused coding and constant comparison***

The second phase of analysis involved ‘focused’ coding (Charmaz, 2006) in which each transcript was re-read and re-analysed applying higher level conceptual categories derived from the initial phase of coding. During this process of constant comparison, categories were adapted and refined to better fit the data and become enriched and extended as a result. Multiple examples and representations of categories were found within the data and this led to the creation of subcategories. Throughout this process the researcher noted possible developing connections or relationships between these categories which were recorded within memos.

As interviews progressed central themes were identified and focused upon, therefore the range of areas discussed narrowed and became more refined. Charmaz (2006) highlights that collection of this increasingly specific data helps to inform the development of a theoretical framework. At the later stages of analysis, memos regarding categories were examined and compared in order to identify further contrasts and connections between them. Through this process five sub-categories emerged which appeared to encapsulate the experiences and viewpoints of participants. Reflection on the way in which these categories related to each other also suggested the existence of one overarching core category which held together each of these subcategories. The researcher then reviewed the material collected through this preliminary theoretical framework, looking for exceptions to categories or examples which exemplified these.

Within this project the researcher met with the research supervisor following each pair of interviews. During these meetings the core theme and sub-categories which were emerging were identified and the researcher and supervisor agreed which aspects of these required to be explored further to deepen understanding. Selected categories were then reintroduced into the subsequent two interviews in order that a

richer construction of these concepts and processes could be achieved. This method of constant comparison (Glaser & Strauss, 1967) is illustrated in Tables 2, 3 and 4 (Appendices 6, 7 & 8). These tables illustrate the way in which categories were actively reintroduced by the researcher or were spontaneously reintroduced by participants.

- Through visual inspection of Tables 2, 3 and 4 (Appendices 6, 7 & 8) it can be seen that during initial interviews not all categories were explored in full, indeed early interviews featured other themes not included in these tables which were seen as extraneous to the theme of recovery and which were not followed up in subsequent questioning. However, as a narrowing of focus occurred during the interview process, the selected categories represented in Tables 2, 3 and 4 (Appendices 6, 7 & 8) were repeatedly revisited to add depth to understanding of these subject areas. Many of the sub-categories were mentioned spontaneously in early interviews by participants and questioning then following naturally. However, if they were not referred to spontaneously in later interviews they were re-introduced by the researcher. For example, as seen in Table 3 (Appendix 7) data relating to the minor sub-category of 'telling the story' was referred to spontaneously by participants 1 and 2, the researcher then carried this category forward in later interviews when it was not mentioned spontaneously by subsequent participants. Similarly, interviews with participants 1 and 2 included spontaneous mention of the core category of recovery as a 'unique, evolving journey'. As interviews progressed this core category was reintroduced either by the participants spontaneously or by the researcher in later interviews. This method of constant comparison allowed incoming data to be compared with existing data and enriched and deepened categories as interviews progressed.

#### **4.4 Quality standards in qualitative research**

##### ***4.4.1 Credibility***

In response to criticisms regarding the subjectivity of qualitative approaches researchers have sought to introduce strategies to enhance and highlight the reliability of findings (Government Chief Social Researchers Office, 2003). Charmaz

(2006) reflected that the credibility of a study could be gauged by reviewing to what extent findings could be seen to accurately represent the views of those interviewed. Credibility checks can therefore involve allowing participants to review findings to gain their feedback as to the representativeness of results.

A further method used to improve credibility is the process of triangulation. Flick (1992) describes this as the process by which understanding of a topic may be enriched by viewing it from a variety of perspectives. It has been suggested that '*triangulating the perspectives of different researchers can enrich the analysis*' (Yardly, 2008, p.240). Triangulation refers to a process of data collection in which understanding is enriched by considering relevant evidence from a number of different perspectives and unrelated sources (Flick, 1992). This process can be achieved by gathering relevant research literature to inform and compare against the data or by having other individuals' perspectives upon the data itself. This can take the form of gathering differing individuals' accounts of the same phenomenon or through having other researchers give their perspectives on the codes and themes which emerge having studied the data (Yardley, 2008).

#### ***4.4.2 Transparency and transferability***

Within quantitative research the predominant approach is to aim to reduce sources of error within data. Efforts are often therefore made to minimise the possible influence of the individual researcher and their potential bias. In contrast, qualitative analysis assumes that the researcher will unavoidably have some degree of influence upon the material generated. This is particularly true given that qualitative research affords the possibility of exploration of material during active interaction with a participant, for example during an in-depth interview. In order therefore to maximise this active engagement with participants whilst ensuring adequate rigour, qualitative approaches require the researcher to seek out, recognise and document their own subjectivity during the research process rather than eliminate it (Peskin, 1988). In this manner researchers are encouraged to make explicit their own areas of interest, assumptions and possible biases and to consider the effect which these might have upon their interpretation and analysis of the material generated.

Yardley (2008) states that good quality qualitative research requires transparency through ensuring that the reader can identify which procedures were followed and why. This allows the reader to independently review the transferability of findings to other contexts. Transparency can be facilitated by the keeping of detailed notes outlining the differing stages of analysis. Consideration of such a '*paper trail*' (Yardley, 2008, p.243) allows the reader to better understand the interpretations of the researcher whilst considering alternative viewpoints. The reader can then more objectively evaluate the researchers influence upon the material generated.

#### **4.4.3 Reliability**

Elliott *et al.*, (1999, p.222) produced a set of guidelines for the publication of qualitative research studies in psychology. Within these guidelines they specified further elements which could be identified within good quality research. These included the presence of credibility checks to monitor the reliability of findings. The reliability of findings can be assessed by the extent to which findings could be replicated if the research protocol were to be repeated (Erlandson *et al.*, 1993). Good quality qualitative research should therefore include an audit trail in order that the process of analysis can be clearly understood and followed.

#### **4.4.4 Confirmability**

The confirmability of a study refers to the extent to which findings can be viewed as trustworthy and not excessively influenced by personal bias or opinion. The 'constructivist' (Charmaz, 2006, p.130) Grounded Theory approach adopted in this study suggests that the researcher cannot and should not remain an independent observer of the data generated. Rather it is accepted that their perspectives, prior experiences, insight and interpretations will influence, inform and interact with the material gathered (Charmaz, 2006). However, the researcher should remain aware of these characteristics and influences, reflect upon them, and be transparent in reporting them throughout presentation of findings.

#### **4.5 Process of inference**

The process of inference employed during analysis will now be outlined to increase transparency of this analysis within this study.

During interviews, the significance of information discussed was inferred by a number of factors. Firstly, the time at which clinicians chose to reflect upon factors and the repetition of these factors during their narratives was reflected upon. Aspects of recovery which the participant wished to highlight were commonly emphasised at the beginning of most narratives, then repeated towards the end of interviews. Clinicians tended to expand upon conceptualisations by giving clinical examples to support their view. The repetition of these viewpoints and clinicians' efforts to provide rich clinical examples which exemplified these characteristics was taken as an indicator of their importance to the participant. Clinicians also directly highlighted that some aspects of recovery appeared not to be purely idiosyncratic to each child but appeared to hold true across many children or young peoples' experiences. Such aspects were inferred to be more central to the recovery.

Difficulty or confusion around particular issues was inferred as a result of qualitative differences in the way in which clinicians reacted when discussing these topics. Changes included verbal indicators such as hesitation in speech, repetition of words or phrases and clinicians contradicting themselves within statements. These aspects of speech, including significant pauses between words, were recorded and were reflected upon in memos completed after each interview. It is acknowledged that these repetitions or hesitations could be interpreted as lack of understanding or confusion around the question posed. However, in many examples clinicians also expressed the fact that they were discussing a difficult or contentious issue, this was therefore reflected upon during analysis. In addition, behavioural indicators were also noted and recorded. These included significant gesticulation by the participant when noting certain points. During these interviews one of the key indicators of difficulty or significance of a topic was also emotion experienced or displayed by the participant. Emotion was inferred within interviews in a variety of manners. Firstly, participants on occasion made direct reference to their own emotionality during

accounts. Secondly, indicators of emotion such as significant changes to tone of voice or posture were recorded and reflected upon. Finally, changes to language were also noted which included hesitation or faltering speech, use of more emotive words and strong reactions such as surprise or disagreement expressed in response to questions asked.

## **4.6 Ethical Issues**

### ***4.6.1 Ethical status of project***

This study was considered by the chairperson for the Research Ethics Committee. The chairperson advised that the project was considered to be an evaluation and therefore did not require ethical review by an NHS research Ethics Committee or approval from the NHS Research & Design Office (Appendix 2). The researcher contacted local clinical governance offices to notify them of the study and check if other review arrangements were required. A full description of this study was therefore sent to both relevant NHS clinical governance offices and the Mental Health Quality Improvement Team who acknowledged the commencement of the study and did not request further information.

### ***4.6.2 Potential distress to participants***

This study required clinicians to reflect on their work with children who had experienced sexual abuse. As a consequence it may have involved reflection on elements of traumatic material. There was a possibility that participants might find reflection on these issues difficult. For this reason all clinicians were made aware of the main topic areas to be explored prior to interviewing in order that informed consent was achieved. However, since reflection on practice is an integral part of the work carried out by the teams included, it was not anticipated that questioning regarding clinical work would present significant distress to staff interviewed. All participants had access to regular supervision. The researcher had also received training within the Doctoral Qualification in Clinical Psychology as regards recognising and responding to distress and agreed to terminate the interview should a participant become significantly distressed.

### **4.6.3 Confidentiality**

Participants were made aware that all information for inclusion in the completed thesis would be made anonymous. They were also informed that audio-recordings of interviews and transcripts would be held on a password protected NHS computer. Participants were encouraged to ask for clarification regarding the aims and objectives of the study at any point.

### **4.7 Participants use of term 'recovery'**

Throughout the course of interviews many clinicians expressed resistance to use of the term 'recovery'. However, no unifying alternative term or phrase was provided by clinicians. Indeed many participants reverted to use of this term despite their own reservations. In addition, when 'recovery' was mentioned, clinicians were immediately aware of the topic which was being referred to. The definition of recovery used by the researcher, which also appeared to reflect most closely the clinicians narratives was that of Deegan who defined recovery as a '*self-directed process of transformation*' (Deegan, 2001, p5). For the sake of clarity this term has therefore been adopted and used within this discussion, however the contentious nature of this word and its implications are acknowledged.

## **5 RESULTS: The unique, evolving journey of recovery**

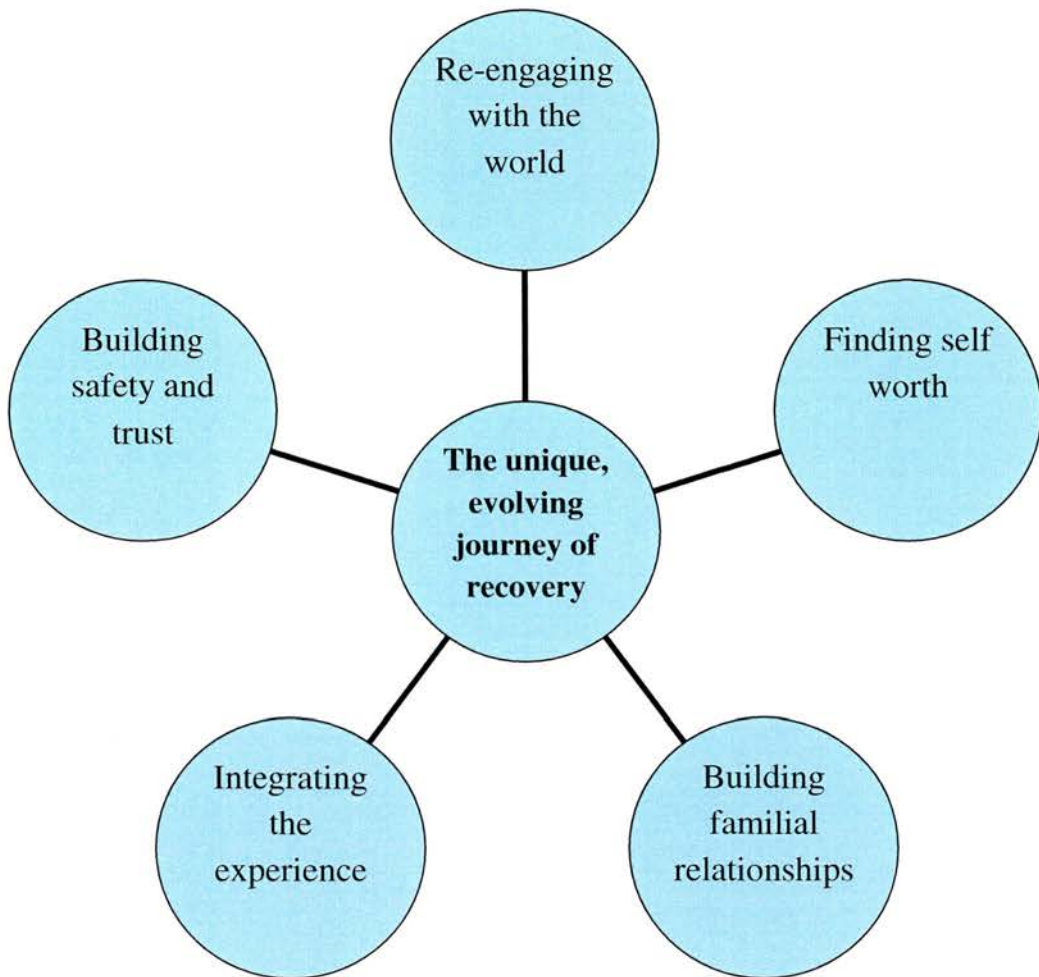
The core category that emerged was that children and young peoples' recovery from sexual abuse was perceived by clinicians as a 'unique, evolving journey' which was likely to continue across the lifespan. The meaning of this recovery journey to clinicians was that individuals would 'get back to being a child' or young person by returning to and moving through natural phases of growth and learning which had been interrupted or distorted through their abusive experiences. Early characteristics of recovery therefore involved intra-psychic changes within the child or young person. These included gaining a deeper insight into their own emotions, starting to integrate their experiences and acknowledge their losses, beginning to find self worth and gaining increased confidence and a clearer sense of their own identity and personal interests. Recovery also meant learning to develop trusting relationships through which belief in the worth of self and others could also begin to be restored. Given the complexity of integrating or making sense of such fundamental traumatic experiences, it was highlighted that recovery would most often occur across the lifespan and involve recurring periods of reappraisal and a need for acknowledgement of loss.

There were six categories which combined to characterise the meaning of recovery. During the process of interviews and concurrent analysis one central theoretical category emerged; 'The unique, evolving journey of recovery'. Five related sub-categories also emerged which represented characteristics of recovery as seen in clinical practice; building safety and trust, integrating the experience, building familial relationships, finding self worth and re-engaging with the world. Figure 1 illustrates the link between the central theoretical view of the unique, evolving journey of recovery and its distinct phases as seen in clinical practice. Each of these categories will now be described in turn.

Excerpts of data from original transcripts will be provided to illustrate these categories. Ellipsis points in brackets indicate omission of text, significant pauses in speech are indicated numerically, speech of the researcher is enclosed within brackets and square brackets indicate aspects of participants' behaviour such as laughter.

**Figure 1:**

**Diagrammatic representation of ‘The unique, evolving journey of recovery’\***



\*See Figure 2, Appendix 9, for diagrammatic representation of all sub-categories.

## **5.1 Central Category 1:**

### **THE UNIQUE, EVOLVING, JOURNEY OF RECOVERY**

The over-riding central category which emerged through analysis was that clinicians viewed recovery from childhood sexual abuse as a unique, evolving journey which was likely to continue across the lifespan. The meaning of this recovery journey to clinicians was that individuals would 'get back to being a child' by returning to and progressing through natural phases of growth and learning which had been interrupted or distorted through their experience of sexual abuse. It was highlighted that this journey was likely to include reappraisal of experiences over time and therefore recovery itself could often continue across the lifespan.

The core nature of this theme was evident as it permeated each of the subsequent categories listed. For example, although building safety and trust emerged as an important aspect of recovery, the way in which this developed would be 'unique' to each child or young person and would be likely to 'evolve' gradually over their lifetime. This theoretical view of recovery as an ongoing journey therefore appeared to be a central theme which had emerged through reflection on recovery as observed in clinical practice. This link between theory and practice permeated all interviews.

Analysis of this theme revealed four sub-categories; unique journey, evolving journey, getting back to being a child and length of the journey. These sub-categories will each now be described in turn.

### 5.1.1 UNIQUE JOURNEY

This first sub-category related to the individuality of each child or young person's journey through recovery. It was highlighted that the route to recovery would be entirely unique to that individual and would be influenced by the child or young person's own perceptions of the abuse experienced.

*'there are so many different journeys to recovery for, for ehm for young people. One person's experience of abuse and their journey to recovery will be very different from another's' (Participant 8)*

Clinicians highlighted that the impact of abuse would also be dependent on a number of other factors including the age of the individual, the nature of the abuse, the child or young person's relationship to the abuser, the subsequent reactions to disclosure and the supports available to them. As a result the effects of abuse would be distinct to each individual and their journey of recovery would therefore be entirely unique.

*'there's different signs of recovery from different children and from different adolescents (yes) ehm because I work with both, I work with both children and adolescents and adults as well ehm for children in particular it, it depends on the nature of, of many things I mean what's happened to them, the relationship they have with their abuser, if they're supported' (Participant 6)*

Reflection on the unique nature of recovery led clinicians to highlight the need for individually tailored interventions designed to meet the needs of each child or young person. However, it was also acknowledged that given the unique nature of each recovery, this journey may take place without any formal therapeutic intervention. Given the unique form of recovery from such an interpersonal trauma, it was emphasised that this journey should be defined by the child or young person themselves.

*'I think with recovery it needs to be what the young, hm, you have to work with the young person on what is their, what do they think it is that means they'll feel better? I think that, you know, you can say well recovery means you are going back to school doing this, this and this but they have to have in their head what feeling better means to them and what they want so you need to work on that together, you need to work with them on that ehm and I just think recovery, yes it needs to*

*be their goals and what they want and I do think in this work you may not get to the place you think you're going to get' (Participant 1)*

*' I think you have to respect what people are saying, they'll get a certain point and that's it and that's fine you know I think you might have ideas about what you might like to do, and I certainly would (mm-hm) you know, or I'd like to see you go to uni and I'd like to see you do this, that and the other and my eyes might be bigger than my ability [ laughs] you know, you can see the potential people have ehm so I think that's part of keeping yourself even (yes) and it's also part of not imposing your kind of wishes on the person'. (Participant 9)*

### **5.1.2 EVOLVING JOURNEY**

The second sub-category reflected the perception of recovery as an ongoing and evolving journey. All clinicians made reference to the fact that recovery may involve reappraisal of abuse experiences over time. It was highlighted that the meaning of the abuse to the child or young person was likely to alter and evolve as a result of natural maturational development and advancement of their own cognitive abilities.

*'I think for me there's something about working with children and young people which is about a developmental stage and the idea of kind of you're probably going to kind of come round the loop and make different senses of experiences over a, over different developmental or kind of cognitive periods' (Participant 12)*

Clinicians' narratives highlighted that the degree of transition and change experienced by children and young people in their early years and adolescence meant that their own journeys of recovery would be equally transient and constantly evolving. There was a sense that recovery was very much an active process in which the child and young person was engaged as they were continually adjusting and developing their own identities. Although clinicians recognised that these processes of development and transition also occurred within adulthood, there was a sense that the amount of change was intensified within these early years.

*'I think things are just less sure for children and there's more transitions for them to go through and ehm you know, the world is not within their control' (Participant 8)*

Clinicians also noted that throughout the lifespan specific events could trigger reappraisal of abuse. These included natural changes in life circumstances such as

entering intimate relationships or becoming a parent. They also included events related more directly to the abuse such as exposure to stories in the media relating to abuse or news of the whereabouts or death of the abuser themselves.

*'if something happens in your childhood it may have consequences for your future sexual relationships say so at different times in your life there may be different needs (mm-hm) and as you pro- you know, as you meet your developmental tasks or, you know, as you have a child you know, there's fairly predictable things where you know that person may need help' (Participant 9).*

*'things like, ehm, finding a life partner, or having a baby brings up, I think especially having a baby brings up a whole lot of other issues and makes the meaning of the abuse, brings a different meaning into the focus and I think at each stage people have to kind of work their way through that (yes) ehm you know, another traumatic event for instance, the, the ehm the death of the abuser, all of those things are, are really ehm, high profile ehm, ehm, case in the media about abuse (yes) all of those things can ehm . . . {{2 secs}} can I suppose bring up things for someone' (Participant 8)*

In summary, all clinicians noted that the journey of recovery was likely to change and evolve across the lifespan as previous experiences were reappraised over time.

### **5.1.3 GETTING BACK TO BEING A CHILD**

This third sub-category encapsulated clinicians' holistic view of recovery which concerned returning to an age appropriate stage of development. It was firstly emphasised that recovery involved transformation of the 'whole' person rather than purely 'symptom' reduction.

*'It's about recognising recovery is a whole person thing (yes) ehm and that, that ehm it's not just about symptoms, it's not just about their cognitions around the, the abuse but it's affected every part of their ehm . . . {{2secs}} their being a person (Participant 8)*

*'I think often that recovery is their sense of being able to get on with being a child and get on with getting on really [laughs] as opposed to a more clinical look at symptoms and the resolution of the not bed-wetting anymore, and the not doing this, which I think can often be, those things can sometimes be resolved without a child feeling particularly better' (Participant 5)*

Clinicians emphasised that sexual abuse could interrupt or halt progress through important developmental stages of learning. As a result children or young people they could become trapped in unhelpful cycles of behaviour or could fall into destructive patterns of interpersonal interaction. It was therefore suggested that recovery involved returning to and moving through age appropriate phases of learning.

*'I think the work that we do is about helping the kids to get back onto that developmental pathway again (OK), so that they're going on that path, where I think before because of life's adverse experiences to them, they're stuck. They're stuck at an early emotional age if you like, so we're trying to help them get back onto that pathway again so we can (yeah), they can tackle life's difficulties and life's ehm troubles.'* (Participant 6)

Given this view that recovery involved natural phases of developmental learning, clinicians expressed their desire not to define this journey with potentially stigmatising or 'medicalised' language. Resistance was expressed to terms such as 'recovery' or 'symptoms' which were viewed as overly 'medicalised'. (See Appendix 10 for additional analysis regarding concerns about stigma). In summary, it was suggested that a characteristic feature of recovery was 'getting back to being a child' which involved returning to and moving through natural phases of growth and learning.

#### **5.1.4 LENGTH OF THE JOURNEY**

The fourth sub-category encapsulated clinicians' views about the possible length of the recovery journey itself. As mentioned previously there was agreement across all interviews that experiences of abuse may be reappraised or processed thereby reducing distress, however, memories of the abuse were likely to remain with the individual. There was therefore acknowledgement that it was not possible to predict the course or length of an individual's recovery. However, there was also recognition of that fact that any recovery process following an experience of complex trauma could be likely to take place over the longer term.

*'I think recovery for these young folk can be a longer process I also think sometimes when you finish off with these young people I would always say that you may feel that in the future you want to come back to some things too I think it can be with you for a long long time' (Participant 1)*

It was identified that the ongoing nature of recovery appeared to be due in part to the permanence of memories which clinicians could not and should not attempt to remove.

*'I guess I don't believe that it ever goes away (yes) because it's all part, it becomes part of your, your, eh, it's an internalised object, an experience' (Participant 10)*

Given the possible permanence of abuse memories, clinicians reflected upon whether the concept of full 'recovery' was in fact possible. Some clinicians viewed abuse acts as so detrimental to the individual that their developmental trajectory would be permanently altered. In that sense these clinicians doubted the possibility of finding an 'endpoint' or point of completion for recovery since the losses experienced by abuse were perceived to be to a large extent irretrievable.

*'I think when a child is, is sexually abused and affected by that it sits with them forever, it, it, you've given somebody something in their head as an experience and so it's, I don't think it's something that you can recover from, I think you can recover from an illness (OK) you know you can 'recover' from a broken leg, you can recover, you know, it can heal itself and be as good as new (...) but I, I don't know that you can recover from sexual abuse. I don't want it to sound as if I mean that people never get over it and never get on with their lives, because I think a lot of people do(...) I think what you learn to do is you learn to live with it (yes) . . . {{2 secs}} in the same way as you might learn to live with a bereavement' (Participant 7)*

In contrast to this view, others maintained that whilst the devastating impact of abuse was undeniable, human growth and learning could occur despite adversity, therefore abuse experiences in themselves did not diminish the individual's potential for growth.

*'I think maybe if you've had horrible ehm childhood experiences, horrible abuse that maybe life will always be quite painful (mm-hm) ehm or, or has a potential to be pretty painful but I don't think that necessarily means that you can't grow and develop and make some really good stuff out of yourself' (Participant 11)*

This topic generated a variety of mixed responses characterised by uncertainty. Four clinicians doubted whether this process ever reached a true end-point at which the individual could be considered to be fully 'recovered'. In contrast, three other participants described a view that full recovery was possible, however these opinions were expressed as hopes rather than certainties. The remainder of participants expressed uncertainty about reaching a final point of recovery. Indeed, some accounts expressed both hopes and doubts about the possibility of recovery, illustrating their struggle with this concept.

*'I think there is an endpoint, there, there will be an end point at that particular, hopefully there's going to be an endpoint or a good outcome at that particular point in your life (mm-hm) ehm . . . {{3 secs}} but truly I guess I don't believe that it ever goes away (yes) because it's all part, it becomes part of your, your, eh, it's an internalised object, an experience' (Participant 10)*

## **RECOVERY IN PRACTICE**

The previous central category of 'the unique, evolving journey of recovery' reflected clinicians' theoretical view of recovery and was described in the last section. However, narratives also included rich descriptions of the meaning of recovery as seen in clinical practice. Analysis revealed five characteristic phases of recovery; building safety and trust, integrating the experience, building familial relationships, finding self worth and re-engaging with the world (illustrated in Figure 3). Clinicians indicated that children may oscillate between these phases. Therefore the order in which they are presented here is not intended to be indicative of a linear process. Each of these phases and their component sub-categories will now be described.

## **5.2 Category 2: BUILDING SAFETY AND TRUST**

The first key aspect of recovery as seen in clinical practice was building safety and trust. This category therefore represents a main finding of the study. The key characteristics of this category will firstly be outlined.

Building safety and trust involved firstly establishing external safety whether in home or therapeutic environments in order that an internal sense of safety may begin to grow. The development of this sense of internal safety firstly involved being believed and having abusive experiences validated. Invalidation of experiences or emotions could lead to self doubt, emotion regulation problems, confusion and self blame. Developing a sense of internal safety also involved building trust through the fostering of nurturing, attuned relationships which could consistently withstand testing of boundaries. Through such relationships, gaining of insight into emotions could then take place. Learning to cope with distressing emotions was viewed as an integral aspect of building a sense of internal safety and therefore was also a key component of building safety and trust. It was highlighted that developing feelings of safety and trust within the child or young person could often be manifested in an increased ability to confide or trust in others who proved worthy of that trust.

Each sub-category within the category of 'building safety and trust' will now be outlined.

### **5.2.1 ESTABLISHING SAFETY**

An important aspect of building safety and trust which emerged was establishing safety. This involved firstly attempting to establish external environmental safety for the child or young person in order that they may begin to build an internal sense of safety. It was reflected that for many children and young people the chaotic nature of their home environments frequently compromised their safety and jeopardised their progress. Clinicians therefore highlighted that an early stage of recovery involved the reducing the child or young person's vulnerability by improving their basic environmental safety and learning skills as regards self care and self protection.

*'You have to think about the, the, the very basic things first, you know things, like accommodation and, and ehm, being able to, being able to not hurt themselves or, or ehm be safe enough not to put them in positions, putting themselves in positions where they're re-abused these sorts of really fundamental things (...) actually the focus of work is much more on, you know, ehm building their, their ehm self care skills, or their, their ehm, ehm, encouraging them to have a routine in their lives or ehm to do sleep hygiene work or healthy eating work or you know these sorts of things are much more about getting to a place where they have the resilience to be able to do the work that they need to do. (Participant 8)*

The importance of establishing safety for children and young people receiving therapeutic input was also highlighted. This involved ensuring the predictability, stability and reliability of the therapeutic sessions themselves by addressing practical factors such as finding a regular time and place to meet and providing this for the longer term if necessary with a consistent clinician.

*'Well it means kind of being there for the child, I mean seeing them on a regular basis, it means longer term work, it means kind of ehm being there on a regular basis ehm seeing them once a week, same time, same place, being consistent, being the same type of person you are, being, try to be consistent in your personality, always starting on time, finishing on time, getting the structural thing right' (Participant 6)*

It was reflected that individuals require sufficient stability to safely embark on trauma focused work to facilitate their recovery. However, it was acknowledged that in some cases it was not possible or ethical to focus on trauma specific work due to continuing unstable home environments. Such ongoing unstable familial environments could therefore be seen to constitute a potential barrier to recovery.

### **5.2.2 BEING BELIEVED**

A second key aspect of building safety and trust was being believed. Since all participants in this study were clinicians, they described the form that 'being believed' took within the therapeutic setting and why this was an important aspect of recovery. It was remarked upon that negative reactions to initial disclosures or

disbelief could have long lasting and damaging effects which could compound the detrimental impacts of the abusive itself.

*'I know from talking to a lot of them, they weren't believed, the investigation was crap, they uhm, uhm nothing, not enough was explained to them, you know I bet you there was loads of other things it's not just because they haven't talked about it. It's that they weren't supported or didn't have a good ehm and you do get you know the kids whose mum doesn't believe them or blames them, or just somehow they feel responsible'. (Participant 5)*

It was therefore emphasised that a fundamental aspect of the child or young person's recovery would be to experience being heard, carefully listened to, taken seriously and believed. Clinicians reflected that this validation could occur out with the therapy setting but could also be initiated in the early stages of therapy by 'meeting the child where they are at'.

*'I think you have to accept where the child's coming from I think you have to really, the word that came into mind when you were speaking was listen, you really have to listen to the child and that means not just the verbal stuff (uh-huh) but the non-verbal stuff, but if you've got to listen to that (uh-huh) I think the child feels heard, and if they feel heard, and listened to and actually accepted and that develops over time' (Participant 6)*

It was highlighted that those who had previously experienced abusive or manipulative relationships may query other peoples' motivations and may have experienced continual invalidation of their emotions and experiences. Therefore initially being believed, heard and validated may in itself be a therapeutic experience which would be likely to have a positive impact on recovery.

### **5.2.3 BUILDING TRUST**

A further important aspect building safety and trust was the sub-category of building trust.

It was emphasised that as a result of previous traumatic experiences, children or young people may view relationships as potentially dangerous and may develop strategies to defend themselves against becoming involved in relationships. Such

conscious or unconscious defensive strategies were described by clinicians and included suspicion of others, hyper-sensitivity to the responses of others and testing out or sabotaging of relationships. It was therefore highlighted that building of trusting relationships could counteract fears and defences and was fundamental to recovery however could be very difficult to achieve.

Detailed accounts were therefore given of the process of building trust. The importance of key characteristics of clinicians which could facilitate the building of trust were emphasised and included reliability, transparency, congruence, trustworthiness and consistency.

*'I think what's essential and what makes the most difference is the relationship and I think that if you can't get a good relationship going in real terms, where they feel believed and that they have somebody that they can trust and if I say I'm going to be there at two o'clock on Tuesday, I'm not late and I'm always there waiting for them. I'm pleased to see them and if they tell me horrible stuff, I'm still wanting to see them the next day (mm-hm) or the next session. That's what counts' (Participant 7)*

It was highlighted that a true collaborative and attuned relationship also involved challenging the child and allowing them to test the boundaries within the relationships thereby establishing trust and respect for the other person.

*'some of the kids, a lot of the kids I work with, you know, have been very badly traumatised and are in care and stuff and they really do, kind of have very kind of self centred and egocentric and omnipotent and and you know . . . {{2 secs}} and it's those kind of kids I would challenge a bit more, very gently, but I think they need to know about empathy and helping other people and I'm a person and they can't just boss me about and and all the time' (Participant 6)*

All clinicians also highlighted the central role of parents and carers in building safety and trust. The fundamental protective nature of supportive parental responses is discussed more fully within the category of building familial relationships.

## 5.2.4 GAINING INSIGHT INTO EMOTIONS

The final sub-category within building safety and trust was gaining insight into emotions.

It was identified that an important aspect of building a sense of internal safety for children and young people involved gaining increased insight and understanding regarding emotions. Developing the ability to reflect on and notice changes in their own emotions was viewed as an important aspect of recovery. Clinicians therefore described the ways in which this could be facilitated within therapy initially through labelling or containment of the child or young person's emotions.

*'I try to kind of in simple terms label what they're feeling (OK) like if they have a fright I'll say 'oh, sounds like you had a fright, seems like you had a fright' and stuff like that or sounds like, or sometimes they'll get, or sometimes I'll feel quite sad during the session and the kid doesn't feel sad but I'll use that feeling so say 'kind of sadness around' or and things like or when they get angry I'll say 'well you're getting quite angry now' so I kind of label their feelings for them because I don't think they know, they don't have that emotional kind of vocab, that emotional intelligence' (Participant 6)*

During recovery clinicians noted that individuals would gain deeper insight onto their own emotions such as confusion, guilt, anger, sadness or shame. This would include finding their own vocabulary to describe feelings, reflecting on times at which they previously experienced these emotions and identifying what currently triggered these emotions. This more detailed linking of emotion to internal or external triggers such as memories or the behaviour of others represented a form of insight into their emotional world which clinicians noted would develop during recovery. It involved taking time to explore the complexity of emotions experienced and the conflict in emotions which could often exist for these individuals.

*'their need to work out and understand the confusion around having whether it's their dad or step-dad that they've had for years who is their one of their main carers and who is also the abuser (mm) and how they can work out all those feelings around that and I think one of the things I'm really aware of now is me not presuming about how they're going to feel about that person (OK) 'cause they have to tell*

*you how they feel and their confusion and I think you're there to help them work out the feelings around it' (Participant 1)*

Finally, 'gaining insight into emotions' also involved gaining an understanding of how to manage these emotions. All clinicians mentioned the importance of learning to cope with and understand difficult emotions, particularly in the context of undertaking therapeutic work which may be trauma focused and may facilitate movement through recovery.

*'I think to, to do abuse focused work needs a number of different ehm I suppose skills and, and strengths ehm for a young person to possess really to be able to do that work, so things like ehm, ehm an ability to, to self-soothe, to manage really difficult ehm emotions and feelings' (Participant 8)*

### **5.3 Category 3: INTEGRATING THE EXPERIENCE**

The second key aspect of recovery as seen in clinical practice was integrating the experience. This category therefore represents a further main finding of the study. The key characteristics of this category will firstly be outlined.

This category encapsulated the need for integration of experiences to occur during the journey of recovery. This involved both ascribing meaning to memories recalled and processing these experiences. Clinicians described the effects of living with fragmented, unresolved or overwhelming emotions and memories. Resulting difficulties included post traumatic stress reactions such as dissociative responses, nightmares, sleep disturbance, hyper-vigilance, increased anxiety and flashbacks. The need for processing was highlighted by some who reflected that attempts to suppress traumatic material could result in the replaying of these experiences. This could occur through firstly being allowed to tell the story of their experiences verbally or through play. This would not only assist processing but provide a clear and important message to the individual that these events should not require to be held as a shameful secret. Moving through recovery also appeared to involve acknowledging loss. It was recognised that losses could be manifested in a number of forms including interpersonal losses experienced during breakdown of relationships

on intra-psychoic losses such as loss of identity or perceived loss of childhood. Finally, clinicians highlighted the importance of integration of experiences for subsequent recovery in order that a person may incorporate these events into their life experience without allowing these events to entirely define them or leave them feeling fragmented or ‘damaged’.

Each sub-category within integrating the experience will now be outlined.

### **5.3.1 TELLING THE STORY**

The first stage of integrating the experience was telling the story. Clinicians reflected that having another individual bear witness to a child or young persons’ account often represented a significant aspect of recovery. It was highlighted that hearing the individual’s account served multiple functions. For example, it was noted that the way in which the child or young person told their story could often communicate to the therapist the levels of processing of these experiences which had taken place through the form and cohesion of their narrative. However, it could also indicate how much the child or young person felt able to disclose, how much they could tolerate their emotions or the extent to which they felt able to trust the therapist. It was also reflected that through telling their story children and young people could find their own ‘voice’ through co-constructing and building a narrative of their experience within a safe environment. Exploring their experiences, however fragmented, could provide the basis for future work regarding building meaning around these experiences and understanding and tolerating the feelings generated by them.

*‘I suppose it’s giving them space to tell their story first as well I think that’s what I would usually do (mm-hm) ehm to tell their story (... )if the young person is able to tolerate that, so getting them to tell your story what their story is (mm) and what’s happened in that kind of way that it hopefully feels like quite a safe environment that they may still processing some of these feelings’ (Participant 1)*

It was acknowledged that there was often significant variation in the extent to which individuals wished to talk over their previous experiences. However, clinicians stated that most children and young people would display a need to talk through certain

aspects of their story or communicate their story through play. Providing an opportunity to tell their story, whether or not they chose to do so, was viewed as very important for recovery as it would send a clear message that it was not wrong to disclose what had happened. Encouraging openness and a willingness to hear the child or young persons' accounts would contrast with the secrecy and threats regarding 'not telling' which they may previously have experienced from the abuser. Clinicians therefore reflected on ways in which individuals may be assisted to tell their story.

*'I think they need to know they can talk about it (yes) and to be helped if it's something, if you get a sense it's something they would quite like to do but they're not able to (yes) then giving them kind of other alternatives like writing it down or ehm we can throw it, we can rip it up at the end of the session or send me a letter, you know that kind of thing, there's different ways, or maybe there's somebody else you'd like to talk to about it'(Participant 5)*

It was highlighted that responses to disclosures could have a significant impact on recovery, therefore clinicians reflected on how they might respond therapeutically whilst hearing these accounts. Common themes emerged with regard to what constituted a positive therapeutic response. These involved providing a safe environment in which distress would be tolerated, 'contained' and 'held' for the child. Four clinicians gave specific descriptions of this process of 'containing' distress.

*'Acknowledging the strength of the feelings (mm-hm) ehm . . . {{3 secs}} and doing so in a way that communicates clearly to the client that although it's utterly horrendous it's not too big for you to cope with (...). Hear it, not judging but caring so you're there, and you're kind of containing it within therapy and then of course they walk out of the therapy room and you try, you make sure as far as you can that they're OK to do that, ehm and they leave it behind with you eh you know, so they kind of physically there's a great symbolism in walking away from it (yes) you know. So you're, it's contained, within that room.' (Participant 4)*

### 5.3.2 ACKNOWLEDGING LOSS

A second aspect of integration of the experience was acknowledging loss. Clinicians reflected that the repercussion of disclosures of abuse could be devastating, causing losses across multiple areas of the child or young person's life. This could include loss of peer relationships, family relationships and previous environmental sources of stability such as home or school. Clinicians reflected that talking through these losses may allow the child or young person to process the events which were happening in their life as they occurred rather than denying these losses which may cause later distress or unresolved grief.

*'I think part of the work, there's a lot of it's to do with the loss of, lots of losses and mourning losses that's what I, I think it's about as well is acknowledging that with the young person and actually helping them put that kind of thing into words you know 'cause they maybe feel it but they're maybe not able to verbalise it that that you know often CSA can be about so many losses as well and that they've maybe not thought of it that way (mm) so so there's maybe more of an awareness of that that they're able to be upset about that I suppose (yeah) but survive that and get through it and kind of see what they still have in the here and now (mm-hm) and what they can work towards sort of thing'. (Participant 1)*

Clinicians reflected that losses were idiosyncratic to each individual and therefore required to be carefully explored and understood in order to acknowledge their importance to that individual. It was noted that many of these losses related directly to the abusive experiences themselves such as loss of virginity, control or dignity.

*'I said 'well just let's make a list of all the things that you've lost, because I think it's good to give them importance, you know?' and the top of her list was virginity (right), not that surprised me and, and interestingly it has come up again, not a lot but another girl much more recently wanted to know about her virginity, because she felt it made her feel different from everybody else' (Participant 7)*

Other losses reflected upon included intra-psychic aspects such as the loss of childhood as perceived by the individual, loss of identity or loss of a view they previously held of themselves. It was reflected that these losses should be acknowledged and that the child or young person should be given space to grieve these should they wish to do so.

*'you [referring to child] really need to get in touch with what has really happened to you and as it were to be able to grieve for yourself, for the smaller child that you were (yes) and that is a very, that sounds easy I think to describe but I think it's incredibly difficult to do because it actually hits the inner core of one's being' (Participant 11)*

### **5.3.3 MEANING MAKING AND INTEGRATION**

Clinicians reflected that a further key aspect of recovery was processing and integrating experiences. It was reflected that this often involved an initial phase of 'meaning making' during which the child or young person began to express the aspects of the abuse which caused distress. This required the clinician not to make assumptions about the meaning of the abuse but to listen to each individual child or young person's account. It was highlighted that the aspects of the abuse which caused the greatest distress to the child or young person were idiosyncratic to each individual and may not be immediately evident to the clinician.

*'the thing that she, most disturbed her was nothing to do with the abuse it was that he called her a 'little bastard' and that completely devastated her, so we have to remember what, what the meaning is to kids' (Participant 5)*

Clinicians then highlighted the importance of integrating experiences rather than attempting to remove or disown them. Examples were given of the way in which this process might occur. These included exploration of specific traumatic memories through indirect play therapy, talking therapies and trauma specific approaches to reduce post traumatic stress reactions through exposure. It was emphasised that recovery involved integration of experiences in order that the individual could begin to move on from these experiences rather than continually trying to suppress or avoid their memory.

*' . . . {{3 secs}} there's something more about integrating the experience really ehm . . . {{2 secs}} so that it, that it ehm . . . {{3 secs}} become part, becomes a more, becomes part of you (yeah) but not something that is, is ehm, is, is driving all sorts of difficult feelings or behaviours but that it's something that is, is, it becomes much more kind of integrated, and, and, and fits in a way (...) so yeah it's more about kind of integrating that experience in a, a less raw and painful way' (Participant 10)*

Clinicians described the meaning of integration within recovery as an initial stage whereby the child or young person could begin to tolerate the reality that the events had occurred in order that they may later begin to view themselves as a whole and integrated person to whom these experiences had happened. This contrasted with attempts to suppress or deny the events which had occurred.

*'I think there's something about ehM accepting this is what's happened and I need to work out a way of how to manage what's happened and then I can become whole again (mm hm) rather than being somebody who's incomplete or damaged' (Participant 3)*

#### **5.4 Category 4: BUILDING FAMILIAL RELATIONSHIPS**

The third key aspect of recovery as seen in clinical practice was 'Building familial relationships'. This category therefore represents a further main finding of the study. The key characteristics of this category will firstly be outlined.

All clinicians repeatedly highlighted that familial attachments were so fundamental to an individual's development and that they had the potential to promote or prevent recovery. Negative familial factors included disbelief of the original disclosure, marital discord, family breakdown secondary to disclosure and chaotic, unstable or abusive home environments. However, it was highlighted that if children and young people could begin to rebuild solid attachment relationships to those closest to them in their home environments, whether this was their biological family, new foster family or those assuming caring roles within accommodated environments, this would be fundamental to their recovery. Key aspects of building familial relationships which could promote recovery included having family members or carers firstly acknowledge what had happened. This would encourage a sense of validation which was previously highlighted as an important aspect of recovery. Parents or carers working through their own emotions would also be important as unresolved parental distress could jeopardise development of nurturing familial relationships. Finally, gaining acceptance within familial relationships was identified as a key component of rebuilding familial relationships. This included parents or carers becoming empowered to gain a greater understanding of their child and their behaviour in order that they may fully accept them for who they are.

Each sub-category within the category of building familial relationships will now be outlined.

#### **5.4.1 ACKNOWLEDGING WHAT HAS HAPPENED**

As previously mentioned one key factor which many believed could be predictive of the form of recovery following abuse was reaction to the original disclosure. Clinicians reflected upon the damaging effects for an individual of not being believed, particularly by family. It was recognised that for some parents or carers acknowledging their child's experience may involve addressing unresolved issues relating to their own childhood experiences. Nonetheless, it was highlighted that an important aspect of recovery for the family was to acknowledge what had happened to the child or young person. Clinicians reflected that this process could be extremely difficult for families to tolerate and could lead them as a result to deny the events had taken place or attempt to minimise them.

*'it's something that everybody wants to sweep under the carpet (yes) and it divides families. It bitterly divides families (right) ehm you know where, particularly where it's a family member, you know, people don't want to believe that this family member's done this thing. People on the side of the child or whoever you know are bitterly angry and that than be really, it divides neighbours, so it's an incredibly divisive thing' (Participant 4)*

All clinicians remarked upon the importance of parents or carers acknowledging that the abuse took place and the significance of their responses following disclosure. This acknowledgement process involved firstly, giving the child or young person permission to talk about what happened.

*'the main thing they have to do is give them permission to talk by saying if you ever want to talk about this you can, you know, you know come and talk to me or your dad, or your gran, or your teacher. Give a list, a very limited list of people, so that they're not telling everybody' (Participant 5)*

The second aspect of this process of acknowledgement involved the parent or carer believing the child's account or taking it seriously and communicating this to them.

*'what I'm just thinking of a young person I saw whose Mum actually did always believe her from the start and that makes a huge difference that, for me that also charts if recovery is going to be you know a bit you know more hopeful. If the non-abusing carer is there and believes and is, is around actually' (Participant 1)*

It was acknowledged that parents or carers often did not give these positive responses at initial disclosure therefore restorative work to provide such reassurance may be encouraged at a later stage. Clinicians also acknowledged that for many children and young people their families would never be able to acknowledge or accept what had happened. In such cases it was reflected that this would be likely to have a severe detrimental effect on recovery due to the possible breakdown of family relations and the feelings of abandonment, rejection, guilt, anger or shame which this could induce in the child or young person.

#### **5.4.2 PARENTS / CARERS WORKING THROUGH EMOTIONS**

The devastating impact which discovery of abuse could have upon families was frequently referred to within interviews. Many clinicians noted that parents or carers actually experienced secondary trauma whereby they experienced symptoms mirroring those of the child or young person. The importance of providing parallel therapeutic interventions where appropriate for parents and carers was emphasised. As a result, this sub-category encapsulated parents and carers need to work through their own emotions. This included exploring their own feelings which may include guilt or helplessness as a result of their inability to protect their child.

*'there has to be somebody meeting the other members of the family too (mm-hm) the other sort of non-abusing carers to to look at pulling this back together and how can they get back on track to being a family again. I think as well when it's out-with the family it's devastating (yes) if parents or carers hear that they've not protected (mm-hm) and they feel that they've not protected their child (mm-hm) and you need there needs to be work around that as well' (Participant 1)*

It was emphasised that during the child or young person's recovery it was important for parents or carers to receive psycho-education in order that they could understand their own feelings, reduce self blame and thereby become more available to support the child or young person. This work included allowing parents or carers the space to

express their own anger or distress about the abuse in order that they could process these emotions and prevent these feelings being projected onto the child or into the family unit as a whole. It was acknowledged that the painful emotions experienced by parents could block them from being able to support their child.

*'I think, you know, for many parents for example, the thought of their child being abused is so guilt inducing that they can't really go where the youngster needs them to go' (Participant 11)*

It was highlighted that parent or carers' own unresolved past experiences, which may include abuse, could prevent them from providing appropriate responses to the disclosure such as reassurance, validation, acceptance and containment. This may also lead to poor attachments to their children. Clinicians therefore reflected that recovery for the child or young person may involve their parents or carers also receiving support to work on their own unresolved issues. It was however acknowledged that for some individuals, their recovery would ultimately always be hampered by the difficulties of their parents whether these related to mental health issues, chaotic familial environments or unresolved abuse histories.

*'it's so key how parents manage ehm that experience (mm-hm) ehm and how they promote the child's recovery really ehm and I think so often the fact, the ones that, where things don't go as you would want them to it's because there's a somewhat chaotic family or there's mental health issues for the, for the parents, or they're struggling with their own triggers (mm-hm) or CSA experiences' (Participant 10)*

*'parents ability to support can have a major impact on a child's ability' (Participant 2)*

### **5.4.3 GAINING ACCEPTANCE**

Clinicians reflected that a final stage of rebuilding family relationships was to empower parents and carers to accept the child or young person for who they are. The first stage of this process involved helping parents to gain greater understanding about their child's behaviour and to learn helpful ways to respond.

*'I see there's sort of an educative role as well (mm-hm) about helping families understand why the children might be just you know this is how they display things, that can help and if a child's listened to and*

*supported (mm-hm) in some way whether it's about strategies or responses to when they're saying you know 'I feel it was my fault' you know that there's a consistent view that when they're saying that with parents or parents are picking up on their distress they're being able to respond to that but respond in a consistent way as well' (Participant 2)*

It was highlighted that inappropriate responses from parents or carers could lead to distancing from the child or young person or alternately becoming over protective. Such reactions would be likely to detrimental to the individual's recovery.

*'she's [referring to parent] overly concerned and protective over her because of her history of sexual abuse and I actually I don't think it's helpful. She almost wants, you know the girl said to me 'she wants to wrap me up in cotton wool'' (Participant 3)*

It was emphasised that parents or parents could often feel disempowered as a result of not understanding their own child's behaviour. This disempowerment could often occur because parents' view of the child or young person had been altered by the fact they had experienced sexual abuse. For example, some clinicians reflected upon parents who had begun to view their child as a sexualised being and had felt unsure as to how to respond to them as a consequence or viewed them as excessively vulnerable and as a result felt unable to provide the degree of protection or support required. It was identified that in such instances recovery could be facilitated through exploring any negative beliefs which the parent or carer might have developed about their child in order that these could be adjusted and the child or young person be accepted within the family.

*'so many children exhibit a wee bit of sexualised behaviour following abuse, a lot of parents really can't cope, they find it really hard to cope with that because they see that as them being suddenly this sexualised person and they struggle with that. So you don't normalise that but you could make it that 'this is so common, as to be normal and actually it will help you settle that down. We don't have to rush in and see a child to do that we need to help you feel back in the driving seat (yes). You've parented them before, you can parent them now but we'll help you with that' so they feel more confident' (Participant 5)*

## **5.5 Category 5: FINDING SELF WORTH**

The fourth key aspect of recovery as seen in clinical practice was finding self worth. This category therefore represents a further main finding of the study. The key characteristics of this category will firstly be outlined.

The category of finding self worth encapsulated changes to the child or young person's perceptions of themselves and their worth as an individual. All clinicians reflected upon the detrimental effect which sexual abuse could have upon an individual's view of themselves. Descriptions included feelings of difference, emptiness, disintegration, stigma, shame, loss of identity and hopelessness. Finding self worth and beginning to challenge or overcome negative views of the self was therefore viewed as a significant and characteristic aspect of recovery which was likely to occur over time. It was acknowledged that finding self worth often occurred through exposure to fundamental interpersonal interactions such as experiencing the feelings of being cared for, accepted and valued, which were often instilled through engagement in sustaining and nurturing reciprocal relationships.

Each of the sub-categories of finding self worth will now be described in turn.

### **5.5.1 INCREASING 'SENSE OF SELF'**

A key component of finding self worth which was identified as an important aspect of recovery was increasing 'sense of self'.

*'Well, like the child's sense of self, I think the child's sense of self has to be, has to be hidden because of the awful things that have happened to them and I think through the work that we do, these senses of self, this sense of self starts to surface' (Participant 6)*

This firstly involved the child or young person differentiating their own identity and behaviour from that of the abuser. It was highlighted that individuals often held internalised negative views of themselves or destructive beliefs about blame and responsibility regarding the abuse. Developing an increased sense of self therefore often appeared to entail reconciling the confusing duality of the abuser's relationship to the child or young person. It also involved beginning to attribute responsibility for

the abusive acts to the perpetrator rather than believing that they held any responsibility for these events. Characteristic signs of recovery therefore included reductions in self-blame and guilt.

*'recovery being part of them being able to, dep- again depending on the case and the age of the child, being able to very much locate what happened with the person that abused them (OK). Feeling very much absolved of all responsibility and guilt and all the things that go with that (OK) so that when they think about it they can feel angry, they can feel, even upset but not traumatised by it' (Participant 5)*

Signs of the individual developing a stronger sense of self also included increased self-care, gaining a clearer sense of their own opinions, likes and dislikes and an ability to let their own character develop and be shown.

*'There's something about them caring about themselves more and looking after themselves and also it being OK to look nice again, usually in my experience with young folk it's much more covered up, no make-up, you know just not looking after themselves and I think when you start to see bits of that you notice that actually.'* (Participant 1)

## **5.5.2 INCREASING CONFIDENCE AND SELF WORTH**

Clinicians identified that a further key aspect of recovery was increasing confidence and self worth. It was acknowledged that the emergence of confidence could take varying forms. For some an increase in confidence could be seen in their play during therapy sessions. Examples were given in which clinicians had noticed play becoming more free and creative and focusing less on themes relating to the abuse.

*'So there's kind of more, there's less repetitive play there's more a kind of exploratory play, they'll start playing with things they haven't played before (OK). They'll start involving ehm other types of figures and creatures (OK) ehm there's a kind of healing, they do a kind of healing thing, a lot of kids will start to ehm instead of the destructive, negative, punishing type play, ehm they, they'll do ehm play in which like dolls will get better or puppets will get better or they'll, they'll use, we've got a couple of medical kits, the medical kits will be used a lot more to make things recover. Things will become ill and will be looked after, so there's more looking after that goes on and there's also a sense of ehm, ehm, fun that returns to the sessions. I mean there's more, there's more eye contact' (Participant 6)*

Increasing confidence outside of therapeutic sessions was reflected an increased ability to problem solve and make decisions for themselves and have confidence in these decisions.

*'she chose to end therapy two years later because she was feeling so much better in herself ehm much more self confidence, the fear had gone ehm largely anyway (mm-hm) (...) she had handled all this and she'd handled a house move ehm taking it all in her stride eh so [sigh] much more resilience and ability I think to sort of sit back and judge the situation (OK).'* (Participant 4)

Characteristic signs of finding self worth included increases in self respect or signs that children and young people were valuing themselves more through their interactions with others. These signs included reduced self harm or risk taking behaviours and increased self respect.

*'more self respect, more self esteem ah an older child I saw when I first met her would go and sleep with anybody. (...) but by the end of it (...) she was saying 'No, I'm not going to sleep with him, he's not nice, he doesn't treat me well' it didn't matter how she was treated before that. So there were more subtle changes if you like in terms of what she was prepared to put up with (OK) and the self respect that she had, so that's really important as well'* (Participant 4)

Recovery also meant children or young people building up a sense of their worth that was not entirely dominated or defined by the fact they had experienced sexual abuse.

*'she needed to try and go out and get an identity that wasn't based on the abuse (yes) and to find interests and hobbies and things that made her feel confident and positive and things that she was capable of'* (Participant 2)

## **5.6 Category 6: RE-ENGAGING WITH THE WORLD**

The fifth and final key aspect of recovery as seen in clinical practice was re-engaging with the world. This category therefore represents a further main finding of the study. The key characteristics of this category will firstly be outlined.

Clinicians reflected that a further key aspect of recovery from childhood sexual abuse was reengaging with the world. This was firstly reflected by a shift in priorities

and interests whereby children and young people were able to reduce their reflection on their internal distress and memories of past traumatic experiences and could turn their attention to the external world and their own alternative interests. It also involved individuals feeling able to reengage with relationships which could prove nurturing and sustaining for them. Finally, for those engaged in therapy it often included moving on from this therapeutic support. It was recognised that further therapeutic may be required at a later stage, however moving on from one phase of therapeutic support was viewed as a significant phase of recovery.

Each of the sub-categories of re-engaging with relationships will now be described in turn.

### **5.6.1 SHIFT IN PRIORITIES AND INTERESTS**

This sub-category related to the way in which the child or young person began to adjust their focus from their internal world and past experiences of trauma to engagement with the present day external world. It was emphasised again that that clinicians did not describe progression through these phases as linear process, rather children and young people could oscillate between these stages. However, recovery appeared to involve an increasing ability to look outward towards external aspects of experience thereby marking a shift in priorities and interests. Clinicians noted that this could often be observed through a qualitative difference in sessions in which the child would appear less preoccupied with distressing internal states and memories and would talk more about their increased involvement with interests and activities of their own choosing.

*'I think there's something about the young person coming, you know and often you start, you wonder about how their week's been or what's you know, and they bring more about out there, than if that makes sense (OK) than you know that they're doing, their more in the world in a way, that they're taking part more in their world that you know they've there's more friends out there, there's ehm, they're noticing more around them actually as well (OK) that sounds really naff, I don't quite know what I mean by that, but they're just more part of what's happening out there than you know when they come in and it's been, and you can see in their way you know they might just*

*be that wee bit more lighter, animated you know, just a bit more, less preoccupied with maybe what's happened to them'.( Participant 1)*

Clinicians reflected that a positive sign of recovery was individuals showing motivation to engage or re-engage in enjoyable activities or interests of their own. It was reflected that such activities could bring a sense of belonging and purpose to children and young people in order that they felt they had a meaningful and valued role. For those who had previously been subjected to abuse or neglect this could be a new or particularly rewarding experience.

*'I suppose the people we're working with, people with past histories of abuse, that often they describe feeling that their lives are very empty (mm hm) and I, I think a lot of recovery is about them feeling that their lives are, are ehm give them something back (OK) and interestingly I suppose that often you get a feeling of getting something back when you give something (OK) and that might be about people having ehm . . . {{3 secs}} a role whether it's you know, a social role or a ehm a work role or an education student role (yes) or something like that and that's what they get the feeling back from, they feel like they fit, they got a place in society (OK) and that the ehm . . . {{3 secs}} ehm and it's things that they value I suppose that's what I mean by sustaining' (Participant 8)*

It was reflected that this also indicated a movement of focus from their own internal world and past experiences or engagement in externalising, self destructive or risky behaviours and to turn instead towards more rewarding, positive activities which could foster feelings of self worth, having a role in society and a value in life. It was acknowledged that later return to reflection on their own internal world may well occur and be necessary. However, engagement in meaningful roles within their life would be likely to be protective for future recovery.

*'a sense of wellness is about doing the things that you enjoy, sharing important things with other people, ehm having a sense of . . {{ 2 secs}} kind of confidence and competence, I mean they weren't words that they used but these were the themes I kind of translated in ehm and communicating, you know, (...)feeling proud of your work at school or feeling like you've earned the brownie badge or whatever it is, so, so kind of all that kind of self-esteem-iness and the good communication and the, the valuing of that stuff but, but those things bring priorities in your life I suppose' (Participant 12)*

The effects of such empowerment for children and young people included enhancement of their own sense of efficacy, achievement and increased sense of control over their own lives.

*'a positive move forward, an ability to take back control of your life, ehm . . . {{4secs}} eh a surmounting of problems (OK) that you know they've overcome things and they actually become stronger' (Participant 4)*

## **5.6.2 RE-ENGAGING WITH RELATIONSHIPS**

A second aspect of re-engaging with the world involved building a sense of connectedness and relatedness to relationships built inside and outside of therapy.

*'I suppose supporting them, building relationships, engaging, all of these things, if we don't work hard to, to also generalise that, so making sure that the outside of CAMHS part of it ehm is introduced and other people become safe people outside of CAMHS then it's almost like 'this is the only place where I'm really understood' (Participant 8)*

Specific examples were given as to the forms of this re-engagement which included building not only familial but peer relationships. It was highlighted that engaging with peers and feeling safe with trusted friends could increase confidence and have the secondary effect of helping them to re-engage with sociable activities.

*'You know because it's about them not, it's about them protecting themselves but not being scared of the world and I think it's that, you know if they're starting to go out with friends again but you're making sure with them is it friends that you know you keep each other safe, you're together, you know' (Participant 1)*

It was therefore identified that re-engagement with peers could increase engagement in enjoyable activities in general. However, it was also emphasised that building trusting relationships in themselves was a positive goal which could bring feelings of connectedness, being valued and loved and give a sense of purpose.

*'you know, enjoyment in taking pleasure in friendships taking pleasure, you know family relationships being happy, family relationships, ehm feeling like you're doing good things' (Participant 12).*

*'I suppose internal things like a feeling of, of fitting, a feeling of being ehm, ehm having people you, you ehm like and are liked by and love and loved by and all of those, those sorts of things so you really have, recovery is about people having the ability to move through those different stages' (Participant 8)*

### **5.6.3 MOVING ON FROM THERAPEUTIC SUPPORT**

A final important stage of recovery highlighted by clinicians was ability to move on from therapeutic support. This constituted an important phase of recovery since it indicated that the child or young person felt a reduced need to receive support from the clinician and a readiness to move on from therapy. It was emphasised that this stage was often initiated by the individual beginning to prioritise other activities in their lives rather than attendance at therapy.

*'she got recorder lessons (yeah) at school at the same time as therapy (uh-huh) so I said to her 'what do you want to do? It sounds like you really like your.. and so do you want to, you know we can have a break?' and (uh-huh) if you want to do that and stuff" and, because she's doing fairly well, so she's opted to have a break at the moment (uh-huh) when she's doing her recorder sessions, so that to me is a sign of she's getting better (yes) if you like so she's doing, she's getting back on this normal developmental track way again, that she's doing music (yes) which is fantastic'.(Participant 6)*

This diminished need for therapy could also be gauged by reduced productivity in therapeutic sessions as the need for contact reduced. This subtle shift was viewed as a positive phase of recovery and indicator of growing independence.

*'She got to a certain place ehm she wasn't using therapy in the same way anymore because she'd formed very positive attachments outside, who were, who she was talking to more freely than with us, with, with me anymore' (Participant 10)*

Despite clinicians' identification that moving on from therapy could be a positive stage in recovery, their narratives also again alluded to the unpredictable or fragile nature of recovery as they acknowledged that those who moved on from therapy may seek input at a later stage. As previously mentioned, all clinicians highlighted that individuals would be likely to reappraise their abusive experiences events over time and may require to return to therapeutic contact at a later time. However, it was

emphasised that a experiencing a 'good ending' to a phase of therapeutic contact was extremely important. Firstly, it could demonstrate that it was possible to have positive endings to relationships which did not generate feelings of abandonment but fostered an increased sense of self esteem and confidence through feeling ready to move on and gaining independence. Clinicians also reflected that such a positive experience of ending therapy may encourage the individual to seek input in the future should this be required.

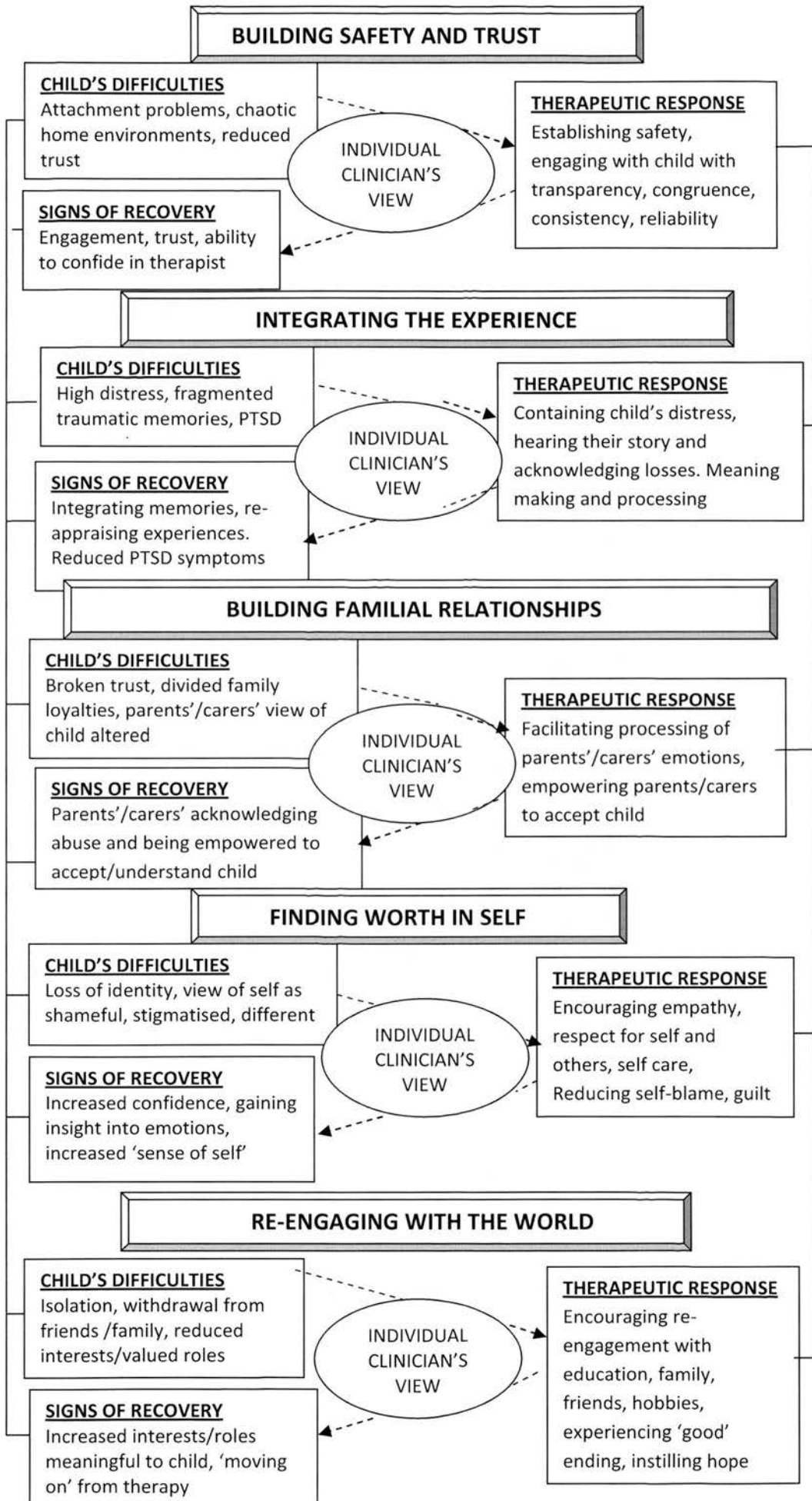
*'what I do try with these young folk is at least to have a finishing off meeting so it feels like they have some kind of ending that's been OK cos you just don't want to be part of another process that the endings just dreadful ehm (mm-hm) so even a letter you know I would do a letter if they can't come in or and just to say might be that in the future they want to do something, so I do I am really aware of endings' (Participant 1)*

Moving on successfully from a trusting therapeutic relationship would therefore be likely to represent a positive stage of their recovery journey.

### ***Summary of phases of recovery seen in clinical practice***

Analysis revealed five characteristic phases of recovery as seen in clinical practice; building safety and trust, integrating the experience, building familial relationships, finding self worth and re-engaging with the world. These phases, their relation to the child or young person's presenting difficulties and possible therapeutic responses described by clinicians are illustrated in Figure 3.

**Figure 3 – Diagram illustrating phases of recovery seen in clinical practice**



## 5.7 SUMMARY OF FINDINGS

These findings illustrated the way in which clinicians working within CSA teams perceived recovery following sexual abuse. They held a theoretical view of recovery as a unique, evolving journey which was likely to continue across the life-span. However, this theoretical view appeared to have flowed from their clinical work. Their narratives therefore also included reflection on the characteristic phases of recovery as seen in clinical practice. These included building safety and trust, integrating the experience, building familial relationships, finding self worth and re-engaging with the world. Clinicians' descriptions suggested that recovery to them meant a lifelong journey of inter-related phases of personal growth and transformation. This appeared to involve returning to and moving through early phases of learning which had been halted or distorted by abuse experiences.

Clinicians' descriptions of recovery included the uniquely developmental aspect of building familial relationships which was viewed as integral in children and young peoples' recovery. During interviews a particular concern over language use was also expressed. This appeared to reflect a desire to remain developmentally sensitive and avoid stigmatisation. A strong desire was expressed to view recovery as a journey of natural growth and learning which involved transformations of the person as a whole.

*'I suppose recovery for me is, is about a person feeling that they, their life has a purpose and a meaning ehm and that they have . . .{{2 secs}} relationships . . .{{2 secs}} that sustain them (mm-hm) and that ehm . . . . .{{5 secs}} I mean there so many different aspects to recovery (mm-hm) and I do think that it's quite a personal thing, (...) I think often in mental health services that's what we measure recovery with (mm-hm) it the absence of sympt-, of of ehm symptoms such as flashbacks, nightmares, low mood whatever but actually I think it's so much more than that (mm-hm) and it's much more about a person's perception of their lives being ehm, having meaning and sustaining them really.'* (Participant 8)

## **6 PERSONAL REFLECTION**

This chapter begins with a section describing reflective process within Grounded Theory. It then includes the personal reflection of the researcher regarding their elective placement within a local CSA team, their evolving understanding of child sexual abuse and their experience of conducting the research interviews.

### ***6.1 Reflective Process***

This study used a constructivist Grounded Theory Approach (Charmaz, 2006). As such it assumed that the themes and meanings drawn from interviews were interpretive and would therefore be influenced by the experiences and assumptions of the researcher. In acknowledgement of this process I kept a personal journal of clinical experiences whilst on my elective placements and a reflective journal which related specifically to research interviews completed. Material from these journals was used to inform the process of analysis and to ensure my own continued reflective stance. I therefore felt it was important to contextualise the observations and interpretations made within this study. This will now be done by reflecting on my own experiences of clinical practice, my evolving understanding of the area being researched and my experience of the interview process itself. Each of these areas was considered within these reflective diaries.

### ***6.2 Clinical practice – elective placement in child sexual abuse***

As noted previously, this study was completed concurrently with my elective placement within a local child sexual abuse team. This was my first experience of working with children and young people who had experienced sexual abuse. My doctoral training in clinical psychology had equipped me with basic grounding in theoretical knowledge of the impacts of sexual abuse and I had only limited experience of working with this client group. I was therefore largely naive to working with children who had experienced sexual abuse. As a result I had a genuine curiosity and open stance towards the possible forms that recovery following sexual abuse might take.

However, this lack of experience also increased my apprehension about embarking on this clinical work. Entries to my journal at the beginning of this placement convey my own doubts about my ability to carry out this work. These include anxieties about the impact of listening to the traumatic content of sessions and insecurities about my own skills as a therapist to give appropriate responses to such material and containing associated distress in the child. I was aware that research literature regarding therapeutic interventions following abuse highlighted the importance of the therapeutic alliance. However, reflections evoke a desire to gain more knowledge about the subject area and to reach a clearer vision of what might constitute 'good' therapeutic input for those who had experienced childhood sexual abuse. Uncertainty appeared to permeate these entries and related to uncertainty about the type of therapeutic approach which I should provide and my ability to provide it. In response I appeared to focus my attention on reading about particular therapeutic strategies and understanding the importance of psycho-dynamic processes which I was also relatively naive to.

As clinical work commenced I experienced strong emotional impacts in response to hearing about the traumatic experiences of children and young people. I became increasingly aware that the language used within adult settings was not commonly incorporated into child work and I felt a reticence myself about use of terms such as 'survivor' or 'recovery' with children or young people. My curiosity regarding these aspects of therapy therefore increased. I also began attending a psycho-dynamic peer supervision group which enabled me to work with colleagues in formulating cases within a cognitive behavioural framework whilst holding an awareness of psycho-dynamic influences. Entries to journal during this period show an increased understanding of the complexities of processes such as transference during sessions.

Finally, in the later stages of my clinical placement I returned to focusing on building relationships with children and young people and enabling them to take the lead in sessions. Through this process my interest returned to what aspects of this therapeutic relationship might help facilitate recovery and why clinicians within child and adolescent fields used such different language to those in adult settings. I also became more curious about the range of approaches which other clinicians

appeared to use, the diversity in opinions relating what approaches might best facilitate recovery and the uncertainty regarding what form recovery might take across the lifespan.

### **6.3 *Evolving understanding of the impacts of child sexual abuse***

Throughout my placement within the child sexual abuse team I struggled with uncertainty. This related to a number of areas including uncertainty about my own skills, uncertainty about the approaches I should use and uncertainty about the form of the transition to wellbeing or ‘recovery’ which we were trying to assist children and young people to work towards. Through supervision and developing confidence gained through clinical work I reduced some of the uncertainty regarding my own skills but retained a sense that tolerating uncertainty might be one of the key features of working within child sexual abuse. This belief has been consolidated by reassurance from colleagues that some of my uncertainties regarding the form of recovery and the aspects of therapeutic process which facilitate it are still held by experienced clinicians. I also found on reading the literature available on this subject that a variety of contrasting models have been proposed to explain the myriad of possible responses to sexual abuse. This evolving understanding of the impacts of sexual abuse highlighted that further exploration of the nature of these processes is valid since a large degree of uncertainty still remains, particularly with regard to the form of child and adolescent recovery.

### **6.4 *Process of research interviews***

This research project constituted my first experience of carrying out qualitative research. Therefore the anxiety and uncertainty about this process mirrored uncertainty and apprehension being experienced in my clinical work. I think these factors alongside my evolving understanding of sexual abuse had a number of effects.

I elected to complete an exploration of the meaning and form of ‘recovery’ within child sexual abuse but soon realised that use of this term in itself caused considerable debate amongst clinicians with some expressing strong resistance to this term itself. I

also met strong resistance at times to my own identity as a clinician whose primary therapeutic approach was cognitive behavioural therapy. These inferences were made without my asserting any allegiance to one particular approach. Clinicians appeared to infer this allegiance through my status as a trainee clinical psychologist. It occurred to me however that these reactions both to language use and my professional identity may have actually prompted valuable discussion of contentious areas of debate related to recovery following child sexual abuse which may otherwise have remained unexplored. I was also aware that most clinicians appeared to rarely step out of their clinical role when talking with me. This was manifested in a reduced tendency to reflect upon personal life experiences or beliefs rather than clinical observations. I wondered whether this may also have been an artefact of my status as a team member and colleague rather than an anonymous researcher.

I was aware through my own work within child and adolescent teams that use of terms such as ‘recovery’ were not common within this setting, however I was surprised by the strength of reaction which many clinicians expressed towards such terminology. During the early stages of interviews I was therefore very conscious of my own language use and became aware of my own hesitancy to use certain terminology during discussions. This could be encapsulated by a feeling of ‘walking on eggshells’ whilst talking with clinicians. I believe this was a result of the strength of feeling which people expressed about this topic area but was also a reflection of my own reduced confidence within the early interviewing stages. However, as interviews developed in parallel with my own understanding of the nature of therapeutic input following sexual abuse, I became more confident in pursuing these more contentious topic issues. Narratives became increasingly focused on the meaning of recovery to clinicians and the concern they had regarding stigmatisation and finding a genuinely developmentally sensitive view of recovery. Exploration of these areas did appear on occasion to evoke stronger emotional reactions. This indicated to me as a researcher that these were ‘live’ issues to the participants as they related to current areas of debate or uncertainty. However, throughout this process I oscillated between feelings of being overwhelmed by exploring these topic areas due to complexity and variability of clinicians’ views, worrying that I would struggle to make sense of this data and being driven to explore these areas further given the

richness of data generated. Reflecting back on the data now I feel that exploration of these less straightforward aspects of clinicians' views has helped me develop a greater appreciation of the complexities of working within this field. However, the richness and contradictions found within narratives suggested that this area warrants further exploration.

## **7 DISCUSSION**

This chapter discusses the findings from the current study in the context of relevant research literature. The implications of the study for theory and clinical practice are also reflected upon. Finally, the chapter gives a methodological critique of the study.

### **7.1 Parallels with current models**

In this first section the parallels between the meaning of recovery to clinicians within this study and existing models of recovery within child and adult literature will be explored.

#### ***7.1.1 The unique evolving journey of recovery***

Clinicians' narratives firstly highlighted the ongoing and evolving nature of recovery following child sexual abuse. The way in which abuse could be reappraised across the lifespan was also identified. It was acknowledged that future events could trigger reappraisal of abuse experiences or cause individuals to return to reflection upon these events. There was therefore uncertainty about the possibility of recovery ever reaching a point of conclusion. Most described doubts that recovery would ever reach a final end point and those who did feel this was possible tended to describe hopes rather than certainties. After consideration of the research literature which includes exploration of adult survivors' views of recovery (Banyard & Williams, 2007), it appears that the ambiguity regarding the 'endpoint' of recovery did not reflect confusion or a lack of understanding amongst clinicians regarding recovery. Rather it reflected a true appreciation of the complexity and characteristics of recovery.

Clinicians' views could be seen to mirror those of adult survivors who have been interviewed regarding their own perceptions of recovery. Within these accounts Banyard & Williams (2007) report that most women interviewed indicated that recovery was never fully possible or was characterised by an ongoing process involving continual change. These women also described recovery as learning new ways to deal with previous experiences, the memory of which would remain with them. This also reflected the opinion of clinicians that attributions regarding abuse

may change over time thereby helping individuals to adjust and cope with memories. However, the underlying memories and their effects would be unlikely to be removed entirely.

The conceptualisation that abuse could halt or stagger progress through typical developmental stages is supported by research literature. Research indicates that childhood abuse can interfere with stage-specific developmental processes. For example, van Gulden and Bartels-Rabb (1995) propose that much of the behaviour displayed by maltreated children or young people is stuck at the developmental age at which they experienced the original trauma. The concept that recovery involved returning to an appropriate stage on the developmental trajectory is also reflected within attachment literature. For example, Osofsky *et al.*, (1995) highlight that therapeutic support for traumatised children can help them to '*return to a healthy developmental pathway*' (Osofsky *et al.*, 1995, p. 605). Clinicians' descriptions of recovery involving 'getting back to being a child' therefore appeared understandable and attuned with current developmental literature which highlighted the potential for abuse to halt or stagger progress through developmental milestones.

Clinicians described five distinct phases of recovery as seen in clinical practice. Many aspects of these phases are reflected within current literature, however the language used to describe them and the differentiation of these phases vary. In addition, some aspects of recovery described within this study were not found within adult literature and therefore reflect a unique developmental view of recovery. The phases of recovery as described within this study will now be contrasted with phases described within current stage models of recovery.

### ***7.1.2 Building safety and trust***

The category of building safety and trust was consistently reflected across a number of stage models of recovery. For example, this phase could be seen to reflect establishing trust and boundaries as outlined by Briere (1996). His research identifies that children and young people who have experienced abuse may show impaired ability to trust others and establish clear boundaries within relationships. This may manifest in mistrust of others or demonstrations of over inclusive '*blanket trust*'

(Briere, 1996, p.xxiv). The phase of building safety and trust within this study is also reflective of the stage of 'stabilisation' described by Brown and Fromm (1986) and 'safety' identified by Herman (1992) each of which involve establishing security and stability within the individual and within the therapeutic relationship.

The sub-category of gaining insight into emotions appears to be reflected upon more commonly within child attachment literature. For example, Fonagy and Target (1997) emphasise the importance of building children and young peoples' reflective capacities and their ability to understand feelings and regulate their emotions. They also emphasise that in order to progress children and young people need to recognise, understand and learn about their emotions within the context of close nurturing relationships. Indeed, Osofsky *et al.*, (1995) highlight that returning to developmental phases of learning requires '*helping young children acquire self-regulation through reciprocal management of affects with an emotionally available therapist*' (Osofsky *et al.*, 1995, p. 605) In summary, research literature supports the view that the phase of gaining insight into emotions highlighted within this study is a significant aspect of recovery.

### ***7.1.3 Integrating the experience***

The phase of integrating the experience also appeared to reflect comparable processes described in the literature. For example, Briere (1996) describes the need for exploration and exposure to the difficult aspects of the trauma experience during the process of recovery. Gil (1991) also recognises the need for similar corrective and reparative processes to take place relating directly to the trauma experience of the child. The treatment strategies suggested by Gil have a clear developmentally sensitive focus and include use of non-directive play to promote healing. Reflection on accounts from adult survivors also resonate with phases of integration within this study such as telling the story, as Banyard & Williams (2007) report that '*acceptance of what happened*' and '*talking about one's experiences*' are important phases of recovery (Banyard & Williams, 2007 p.285).

Herman's (1992) adult model of recovery places more emphasis upon the process of remembering and mourning which takes place during integration. Clinicians'

narratives within this study also included recognition of such processes of grieving. These are encapsulated within the category of acknowledging loss. Although both phases are comparable in their direct relation to loss there appears to be a greater focus on the importance of mourning within Herman's model which predominantly focuses on adult experience (Herman, 1992). Clinicians' accounts within this study promoted the acknowledgement of loss but described an active process in which children and young people were enabled to acknowledge losses as they occurred and to receive support during these periods. It would seem reasonable that adult survivors may develop a greater need to reflect on the overall losses they experienced and grieve these losses once they have gained more perspective on these events over time. Within this study clinicians' descriptions of individuals' needs were qualitatively different, with children and young people often displaying a need to have their losses acknowledged but also expressing a desire to move on from rather than reflect upon these losses for extended periods. Therefore although aspects of the phase of integrating experiences mirrored elements of adult models, clinicians' descriptions held a distinctly developmental view of this stage of recovery.

#### ***7.1.4 Finding self worth and re-engaging with the world***

The category of finding self worth is also represented in the literature. However, again this phase is given differing labels within the literature and holds subtle differences when compared to adult models. These similarities and differences will now be explored.

Herman (1992) describes a phase of reconnection which subsumes both the individual's recreation and rediscovery of self and also their reconnection with their peers, their environment and the outside world. Similarly, adult survivors describe establishing '*connections with others*' as an important phase of recovery (Banyard & Williams, 2007, p.285). In contrast Briere conceptualises these phases as a two part process. He describes '*reparation of the self*' (Briere, 1996, p. xxv) through reduction of shame and guilt and increases in mastery and control and a second phase of looking to the future. After initial review of research literature it would seem that within this study clinicians' descriptions of finding self worth mirror many aspects of

reparation and rediscovery of the worth of self as conceptualised by the literature in differing forms. Descriptions of the phase of re-engaging with the world are also mirrored by stages such as reconnection (Herman, 1992) and looking to the future (Briere, 1996) also found within the literature. However, in exploring the differences between finding self worth within the current study and existing models of recovery, subtle differences did emerge. Reflection on the theme of *'making peace within oneself'* found within the study of Banyard and Williams (2007) does not present a clear comparison with themes emerging within this present study. This may be due to the increasing reflective abilities of adult survivors. The women who took part in Banyard and Williams's (2007) study reflected upon their experiences and found increased reconciliation or 'peace' within themselves. Clinicians' narratives within the present study suggested that children and young people may be situated within an active place of processing recently occurring distressing events. Efforts to 'make peace' with the situation may be premature at this point in their recovery journey.

Overall, review of this literature suggests that the underlying phases which emerged within this study mirror some of those previously identified within research literature. However, the alternative language used and sensitivity to the child's stage of development within this study have generated a theory and narrative regarding recovery which is uniquely developmental in its focus. Clinicians within this study were keen to emphasise that individuals often oscillate between these phases of recovery, as such the route to recovery was not a linear one which might be easily predicted by the individual or the clinician. This particular view of recovery was supported by a number of researchers (Herman, 1992; Kepner, 1995). For example, Coutois (2004) suggests that it is most helpful to conceptualise recovery as a *'recursive spiral'* (Coutois, 2004, p.418). Indeed, Barringer (1992) asserts that the reparative process following sexual abuse should not be viewed as linear but rather *'as spiral, as a repeated traversing of the issues, layer by layer, piece by piece, sorting and resorting, until the toxicity of the abusive experiences has been released'* (Barringer, 1992, p. 15).

In summary, it can be seen that current models of recovery do include many features of the meaning of recovery as described by clinicians. The ongoing, evolving nature

of recovery has been acknowledged within research undertaken with adult survivors (Banyard & Williams, 2007). Aspects of the phases of building safety and trust, integrating the experience, finding self worth and re-engaging with the world are also reflected within existing stage models of recovery (Briere, 1996; Herman, 1992). However, the phase of rebuilding familial relationships was not commonly found within current adult stage models. This uniquely developmental stage is therefore discussed in reference to relevant literature.

## **7.2 Unique developmental view of recovery**

This exploration of clinicians' views revealed that building familial relationships was considered to be a central feature of recovery for children and young people. This aspect of recovery was less frequently reflected upon within adult literature (Banyard & Williams, 2007). This phase will now be explored with respect to relevant literature.

Clinicians highlighted the need for all children and young people to develop a sense of belonging and being cared for by parents, carers or guardians, whatever their home environment in order to facilitate recovery. The sub-category of acknowledging what has happened described the difficulty which this process could present for parents and carers and the importance of the child feeling able to talk about their experiences. Review of the literature confirmed the importance of those around the child being open to listen to their experiences. For example, Perry (1999) outlined a range of positive responses which could be adopted when carers were engaging with traumatised children or young people. These responses reflected those outlined by clinicians and included being open to hearing about the individual's traumatic experiences should they wish to talk about them and providing consistent, reliable, comforting and nurturing responses to these disclosures.

Within this study clinicians also reflected on the need of parents and carers to work through and process their own emotions as regards the child's experience of abuse in order to facilitate recovery. It was highlighted that the child or young person's recovery often required parents and carers to process their own emotions, secondary

traumatic reactions or personal trauma history. The importance of these processes is reflected within research literature. For example, Steele (2003) notes that children or young people who form attachment relationships with parents or carers who have unresolved trauma histories of their own are likely to experience continual distress and emotional dysregulation as a result of their parent or carers inability to provide an attuned containing relationship and home environment. Indeed, Howe (2005) also recommends that parents and carers own unresolved issues should be addressed first in order to ensure the best outcome for the child or young person's own recovery. Juffer et al (2003) described therapeutic interventions which encourage parents or carers to become increasingly sensitive, mind-minded and responsive to their child in order to facilitate recovery.

The final sub-category of gaining acceptance included processes through which parents and carers might gain understanding regarding the child or young person's behaviour following trauma in order to fully accept them as a person. The importance of parents and carers developing their capacity for empathy, sensitivity and responsiveness in an emotionally containing and nurturing way was emphasised. Clinicians highlighted that this would form an important aspect of the child or young person's recovery. Such approaches have been evidenced within the literature for example Howe (2005) emphasises the need for parents and carers to develop capacity for empathy, reflective function and '*mind-mindedness*' (Howe, 2005, p.218). The use of '*affect synchrony*' (Howe, 2005, p.218) is also described as a means by which carers can mirror their child's affective states and alter their responses in accordance with the child or young person's needs. Through this process the child or young person could begin to experience attuned, safe and reciprocal relationships through which their own reflective skills may develop.

In summary, the phase of building familial relationships could be seen to be a key feature of children and young people's recovery which was not commonly reflected within adult stage models of recovery. The validation of the importance of this phase can be drawn from current attachment literature.

### **7.3 Concerns about stigma**

In consideration of the material gathered within this study, a pervasive concern about stigmatisation was notable. The degree of concern about language use and fear of stigma expressed by clinicians was not as commonly reflected within adult literature therefore the significance of these concerns will now be explored.

Existing literature supports the association between experience of sexual victimisation and subsequent experience of stigmatisation and powerlessness (Cohen, 2008; Finkelhor & Browne, 1985). The research of Andrews et al (2000) has identified shame, which is commonly recognised as a core feature of stigmatisation (Cohen, 2008), as an independent predictor of post traumatic stress symptomatology. Clinicians' desires to avoid such dynamics are understandable given the intrinsically relational nature of psychotherapeutic approaches. However, the effect which these factors had upon clinicians' language use and conceptualisations of recovery and treatment responses was unexpected. In particular the strength of feeling expressed with regard to language use was noted. This resistance to language commonly found to be acceptable within adult settings is not commonly reflected upon or discussed within current research literature. Indeed, much of the specifically developmental literature make use of terms such as '*symptoms*' (Carr, 2006), '*healing*' (Gil, 1991) and '*recovery*' (Adams & Fey, 1987; Briere, 1996; Pughe & Philpot, 2007). It would therefore appear that there is scope for further exploration of the current conceptualisations of recovery within child and adolescent settings as both language use and conceptualisations have encapsulated a uniquely developmental stance which current developmental literature does not always reflect.

The appropriateness of assuming a developmentally sensitive approach to treatment interventions following child sexual abuse has been recognised. Shirk (1988) acknowledges that adopting a developmental and attachment aware perspective can allow the therapist to respond to the dependency needs of the child. The strong desire to utilise a developmentally sensitive response style is therefore empirically justified. However, the findings of this study highlight the challenges in doing so. For example, clinicians' sometimes reverted to use of medicalised language or use of the

term 'recovery' despite their reservations. This may reflect the lack of a unifying and established developmentally sensitive framework regarding recovery, to which they could refer. It could therefore be that a genuine gradual change of paradigm towards a more developmentally sensitive view of recovery in child sexual abuse is emerging. However, the language to support this shift has not yet fully evolved or become established.

The lack of cohesion amongst research to support particular approaches would appear to compound these difficulties and heighten uncertainty. As reflected earlier, in many cases the strong reactions to language use and appropriateness of particular therapeutic approaches may have reflected clinicians underlying strength of feeling regarding desires not to re-stigmatise children or add to their feelings of powerlessness. However, variability in developmental theories and empirical evidence regarding recovery and treatment following child sexual abuse would appear to leave clinicians with inconsistent guidance as to how best to facilitate recovery. The task of clinicians to avoid dynamics such as dependency, whilst forming strong alliances with traumatised children in order to promote recovery is therefore particularly challenging given the lack of empirically validated guidelines.

#### **7.4 Clinical Implications**

Clinicians within this study viewed building familial relationships as an integral phase of recovery. Research literature can be seen to support the importance of familial attachments on future recovery. This finding has significant implications for clinical practice as it highlights the importance of working systemically, with not only children or young people but the interpersonal systems in which they live. This finding also highlights the detrimental impact upon recovery of breakdown in foster care supports, lack of resources for accommodated children and young people or continuing conflict or lack of support within familial homes.

It appeared that the meaning of recovery to clinicians was a child-led transformation which involved returning to and moving through developmental learning phases. This view implies that clinicians should attempt to guide and shape this process by

encouraging these natural phases of growth to occur within and out with therapy. This highlights the importance of increased coordination between child and adolescent mental health services and community services and networks and systems, since these systems may be the places in which children and young people are gaining many of their skills. The importance of developing trauma aware systems which may be able to respond in an attuned manner to such children would be likely to promote recovery. The concern regarding language use expressed by clinicians also highlights the importance of training those working with such individuals to use non-stigmatising language both within and out with therapeutic settings.

The strong similarities between recovery as described within this study, and current adult models of recovery conflicted with the resistance clinicians expressed to making such comparisons and using language such as 'recovery'. Although recovery as seen in clinical practice did reflect processes described within adult literature, clinicians were hesitant to call it such. This tension is an interesting paradox and therefore warrants further exploration.

## **8 Methodological critique**

### ***8.1 Limitations of the study***

This study sought to explore the meaning of recovery following child sexual abuse to clinicians working in this field. Use of an inductive rather than deductive approach seems justified. A Grounded Theory approach was selected to meet the projects aims of constructing a theory of the way in way clinicians conceptualise recovery. However, alternative qualitative approaches could have been adopted. As interviews progressed it was evident that there were unique areas of personal experience less related to the topic of recovery which were not explored in detail due to the aims of deepening prominent emerging themes. This included individual accounts of the way in which spiritual or cultural influences had shaped their view of recovery. However, it is acknowledged that use of an alternative methodological approach in combination with a research question intended to purely explore individual experience may have allowed explorations of these uniquely personal themes. A methodology such as

Interpretative Phenomenological Analysis (IPA) could have been adopted to achieve such aims (Smith & Eatough, 2007; Smith 2004).

In considering other limitations of this study the complexity of the research question posed must be acknowledged. The opening question ‘from your experience can you describe your understanding of recovery within child sexual abuse?’ generated rich descriptions of both clinicians’ theoretical view of recovery and the phases of recovery as seen in clinical practice. However, it is recognised that more detailed analysis of each of these aspects of recovery could have been achieved by focusing questioning on only one of these areas. Analysis of the resulting narratives was complex and the clarity of findings may have been enhanced through focusing on one of these areas alone. Interviews generated complex, rich and sometimes contradictory information. The challenge and at times difficulty that this presented with regards to making sense of the data and allowing common themes to emerge, is acknowledged. Initial analysis included a broad range of categories which then required to be reduced substantially in order to enhance the clarity of the findings.

Constructivist Grounded Theory (Charmaz, 2006), places less emphasis on theoretical saturation of categories than earlier versions of Grounded Theory, therefore this study did not aim to reach theoretical saturation. Although a high degree of consistency was found within the main categories it must be acknowledged that the depth and remaining complexity of some themes generated suggested that true theoretical saturation was not achieved. The complexity of the subject matter and heterogeneous nature of theoretical orientation of clinicians is likely to have impacted upon the variability of conceptualisations presented. However, this multidisciplinary sample does reflect the character of teams currently working with those who have experienced sexual abuse.

An additional limitation of the study which should be noted was the fact that only two male participants were included in the sample. As a result, a detailed exploration of the impact of gender upon perceptions of recovery and therapeutic work was not possible. This limitation was a result of the composition of the teams included in the

study in which there were a reduced number of male clinicians. However, recognition should be made of this fact as a limitation of the study.

A final limitation of this study was the fact that participants were only interviewed once. Given the complexity of their accounts which included contradiction and discussion of topics of contention it would have been extremely valuable to discuss these issues further with participants in follow up interviews. Indeed, Charmaz (2003) has criticised reliance on singular interviews stating that this reduces the extent to which the researcher may become absorbed in the individual experiences of the participant. However, due to time constraints this was not possible.

## **8.2 *Strengths of the study***

This study explored the views of clinicians currently working within the field of child sexual abuse. Current literature has less frequently explored the views of clinicians working within this area but has justifiably tended to focus on the experiences of survivors themselves (Banyard & Williams, 2007). This study therefore provides a useful insight into the meaning of recovery as perceived by those working in this area. It also allows the cumulative experience and clinical skills of practitioners to be heard and valued. The main focus of the study was also directed by clinicians themselves therefore the topic of recovery was viewed as relevant and interesting to those currently working within this area.

Recent research within literature regarding adult survivors has begun to move from purely documenting the prevalence and negative impacts of abuse to exploring factors which mediate recovery (Merrill *et al.*, 2001). However, research regarding children and young people has tended to focus on the impacts of abuse and the factors which predict resilience and recovery rather than exploring the form of recovery itself (Luthar, Cicchetti & Becker, 2000). Banyard and Williams (2007) have also recommended the use of qualitative research methods to compliment quantitative studies already completed in this area. This qualitative study therefore provides an initial exploration of the form recovery in a less commonly researched population using the less frequently employed methods of qualitative research.

### **8.3 *Quality standards of qualitative research met within this study***

As outlined previously, good quality qualitative research should include use of particular processes designed to improve the credibility, transparency, reliability and rigor of research produced. The efforts made to consolidate the quality of the qualitative research within this study will now be detailed.

A number of credibility checks were used within this study in an effort to ensure that the findings produced accurately reflected the views of those interviewed. One such process used was triangulation in which understanding of an issue could be enriched by viewing it from a variety of perspectives and independent sources (Flick, 1992). As described previously this can be achieved by gathering relevant research literature to inform and compare against the data, by having other researchers give their perspectives on the codes and themes which emerge or by gathering views regarding the same phenomenon (Yardley, 2008).

Within this study efforts were made to use triangulation to deepen understanding of the subject area. Literature regarding child sexual abuse was continually gathered and reflected upon during the process of research development, data collection and analysis. Information from this source was used to inform understanding of the gathered material. In addition, the credibility of emerging themes was checked by incorporating these themes into subsequent interviews to assess their representativeness with other clinicians. A further form of triangulation was used as the researcher's academic supervisor gave feedback as to the consistency and validity of codes and themes assigned to the material throughout both open and focused coding of all transcripts. Two additional supervisors then reviewed the developing theoretical framework and gave continuing feedback as to its goodness of fit in relation to the data collected. These inter-rater comparisons ensured that the codes and emerging themes identified made sense to others viewing the interview material. Adjustments made to analysis in later stages of the research were also overseen by two academic supervisors.

Following the analysis all participants were invited to attend a formal presentation of this project where the main findings were disseminated. This occurred during a local

meeting of the three teams who participated. The researcher gained verbal feedback from clinicians regarding the extent to which the research findings were an accurate reflection of their interviews. Clinicians reflected that the findings appeared representative of their views and none of the clinicians stated that they felt they were misrepresented within the study. It should however be acknowledged that a number of clinicians who participated in the study were unable to attend this meeting. Therefore the rigour of this credibility check could have been improved by writing to each individual participant, however the time restrictions of this project prevented this occurring.

Good quality qualitative research also includes high levels of transparency which can be achieved through the researcher seeking out, recognising and documenting their own subjectivity, areas of interest and possible biases during the research process (Peskin, 1988). Within this study efforts were made to increase transparency of the research process. The researcher made explicit their own developing interest in the ways in which the therapeutic alliance could be utilised to facilitate the process of recovery. The researcher also outlined their early naivety to the subject area and reflected upon possible biases or effects which their role as a trainee clinical psychologist may have had upon their own assumptions and those of the participants interviewed.

Yardley (2008) states that good quality qualitative research requires transparency through ensuring that the reader can follow which procedures were followed and why. Such evaluation of this process can be facilitated by the keeping of detailed notes outlining the differing stages of analysis. Consideration of such a '*paper trail*' (Yardley, 2008, p.243) allows the reader to better understand the interpretations of the researcher whilst considering alternative viewpoints. Within this study the researcher kept a reflective diary throughout the research process and content from this was discussed during the study, excerpts from this diary were also made available within the appendices. The researcher did not however carry out a Grounded Theory analysis of the data from this reflective diary. Carrying out such formalised analysis of reflective logs may have yielded more detailed insights into the processes of analysis which would have further increased the transparency and

assisted the reader in understanding and following the interpretations of the researcher. This is recognised as a further limitation of the study.

## **9 Concluding Statement**

Within this study clinicians perceived recovery from sexual abuse as a unique, evolving journey which was likely to continue across the lifespan. The meaning of this recovery journey to clinicians was that individuals would return to and move through natural phases of growth and learning which had been interrupted or distorted through their abusive experiences. Five phases of recovery emerged; building safety and trust, integrating the experience, building familial relationships, finding self-worth and re-engaging with the world. This study also highlighted a paradox which emerged between the similarities of the phases of recovery to current recovery models within mental health and clinicians' resistance to describe recovery with such language.

Clinicians' conceptualisations reflected a uniquely developmentally sensitive view of recovery which was not always reflected within current literature and the significance of familial influence during recovery was emphasised. Resistance was expressed to particular language and concepts often utilised within adult settings. Throughout clinicians' narratives particular concern was also expressed to protect against the effects of stigma. In addition, it appeared that the complexity in facilitating children and young people's progress through recovery may have been compounded by a lack of unifying theoretical frameworks regarding this issue and a paucity of specific system level guidance as to which therapeutic approaches should be employed. The considerable challenge faced by clinicians in tolerating these uncertainties whilst attempting to provide assessment, formulation and intervention for children and young people was highlighted in this study. This study also invited further research in this area to assist clinicians with this complex task of integration but also to explore the tensions and paradoxes which emerged through the contrast between clinical practice and language used to describe this.

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## Appendices

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**Formal Documentation – Liability Insurance / Sponsorship**

Clinical Trial Liability Insurance

Co-sponsorship documentation



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*To whom it may concern*

**MISS LORNA S MCARTHUR**

This letter will confirm that Miss McArthur is a 3<sup>rd</sup> year student at the University of Edinburgh, studying for the degree of DCLinPsychol in the School of Health (Clinical Psychology). As such, she is formally recognized as a student under the auspices of the University's regulations and is formally supervised within the School of Health in Social Science

Mrs Anne Fernon  
On behalf of the College of Humanities and Social Science

14 December 2007



**TO WHOM IT MAY CONCERN**20<sup>th</sup> July 2007

Dear Sir / Madam

**The University of Edinburgh – Clinical Trial Liability Insurance**

As Insurance Brokers to the above, we confirm details of their annual Clinical Trial Liability Insurance as follows:-

|                            |  |
|----------------------------|--|
| <b>Insurer</b>             | Royal & Sun Alliance   |
| <b>Policy Number</b>       | SA13612942   |
| <b>Renewal Date</b>        | 1 August 2008  |
| <b>Cover</b>               | (A) Legal liability for accidental injury to any Research Subject arising out of participation in a Clinical Trial.<br><br>(B) Compensation for accidental injury of any Research Subject participating in a Clinical Trial. The amount of compensation paid being appropriate to the nature, severity and persistence of the Injury and, in general terms, consistent with the quantum of damages currently awarded by a Court where legal liability is admitted. |
| <b>Limit of Indemnity</b>  | (A) £10M any one claim and the aggregate during any one period of insurance.<br><br>(B) £5M any one claim and in the aggregate during any one period of insurance.<br><br>Subject to the total amount payable under both items (A) and (B) not exceeding £10M during any one period of insurance.  |
| <b>Geographical Limits</b> | Any Trial undertaken within Great Britain, Northern Ireland, The Channel Islands and the Isle of Man.  |

I trust that the above details are sufficient for your requirements, but please do not hesitate to contact us if you require further information.

Yours faithfully

Alan Parker  
Client Service Adviser  
For and on behalf of Aon Ltd

Direct Dial Number: 0131 456 3074

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**TO WHOM IT MAY CONCERN****20<sup>th</sup> July 2007**

Dear Sir / Madam

**The University of Edinburgh – Liability & Professional Indemnity Insurances**

As Insurance Brokers to the above, we confirm details of their annual Liability & Professional Indemnity Insurances as follows:-

**Employers Liability**

|                    |                               |
|--------------------|-------------------------------|
| Insurer            | Royal & Sun Alliance & Others |
| Policy Number      | 47SQ41024501                  |
| Renewal Date       | 1st August 2008               |
| Limit of Indemnity | £50M any one incident         |
| Includes           | Indemnity to Principals       |

**Public/Products Liability**

|                    |   |
|--------------------|---|
| Insurer            | Royal & Sun Alliance & Others   |
| Policy Number      | 47SQ41024501  |
| Renewal Date       | 1st August 2008   |
| Limit of Indemnity | Public Liability - £50M any one incident<br>Products Liability - £50M any one accident and in all during the period |
| Includes           | Indemnity to Principals   |

**Professional Indemnity**

|                    |   |
|--------------------|---|
| Insurer            | Royal & Sun Alliance                            |
| Policy Number      | SA11209390                                      |
| Renewal Date       | 1st August 2008                                 |
| Limit of Indemnity | £10M any one claim and in all during the period |

I trust that the above details are sufficient for your requirements, but please do not hesitate to contact us if you require further information.

Yours faithfully

Alan Parker  
Client Service Adviser – Commercial Insurance Division  
For and on behalf of Aon Limited

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The Queen's Medical Research Institute  
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**Research and Development Management Suite**

13 December 2007

Miss Lorna McArthur  
Child and Adolescent Mental Health Service  
Royal Edinburgh Hospital  
Tipperlinn Road  
Edinburgh  
EH10 5HF

Dear Miss McArthur

**Study Title: Grounded Theory Study of Recovery in Child Sexual Abuse  
- Exploration of Perceptions and Clinical Work of Clinicians  
REC: To be obtained**

Under the requirements of the Scottish Executive Health Department's Research Governance Framework for Health and Community Care, the University of Edinburgh and NHS Lothian Health Board agree in principle to act as co-sponsors for this project. Co-sponsorship is subject to you obtaining a favourable ethical opinion and NHS Lothian R&D management approval.

As Chief Investigator, you must ensure that the study does not commence until all applicable approvals have been obtained.

Please note this letter should not be considered as NHS Lothian R&D management approval.

Following receipt of all relevant approvals, you should ensure that any amendments to the project are notified to the co-sponsors, REC, MHRA (where appropriate) and NHS Lothian R&D Office.

Yours sincerely

Heather Cubie  
Director  
Research & Development Office  
NHS Lothian

Marise Bucukoglu  
Associate Director  
Edinburgh Clinical Trials Unit  
University of Edinburgh

cc NHS R&D Office  
Edinburgh Clinical Trials Unit

**Documentation regarding ethics**

Ethics board confirmation of study as evaluation – no ethical approval required.

Documentation from R&D office to confirm no further approval required

Scotland A Research Ethics  
Committee

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Ms Lorna McArthur  
Child Sexual Abuse Service  
Royal Edinburgh Hospital  
Tipperlinn Road  
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EH10 5HF

Date: 21 December 2007  
Your Ref.:  
Our Ref.:

Enquiries to: Walter Hunter  
Extension: 89026  
Direct Line: 0131 536 9026  
Email: walter.hunter@lhb.scot.nhs.uk

Dear Ms McArthur

**Grounded theory study of recovery in child sexual abuse: Exploration of perceptions and clinical work of clinicians**

I refer to our recent exchange of e-mails about whether the above project required ethical review.

You provided the following documents for consideration by the Chairman:

REC application form parts A and B

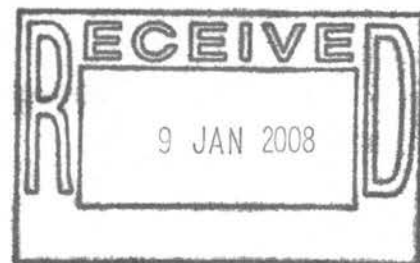
This document has been considered by the Chairman. The Research Governance Framework (RGF) sets out the responsibilities and standards that apply to work managed within the formal research context. The Chairman has advised that the project is considered to be an evaluation and should not be managed as research. Therefore it does not require ethical review by a NHS Research Ethics Committee or approval from the NHS R&D office.

You must check with the clinical governance office for NHS Lothian what other review arrangements or sources of advice apply to projects of this type. You should ensure that the project is not presented as research in the NHS organisation.

This letter should not be interpreted as giving a form of ethical approval to the project, but it may be provided to a journal or other body as evidence that ethical approval is not required under NHS research governance arrangements.

Yours sincerely

**WALTER HUNTER**  
Committee Co-ordinator



Chairman Professor Kennedy Lees  
Vice-Chairman Dr George Masterton  
Vice-Chairman Dr Malcolm Booth

University Hospitals Division

**Queen's Medical Research Institute**  
47 Little France Crescent, Edinburgh, EH16 4TJ

HAC/SM/standardletters/audit

19th March 2008

Miss Lorna McArthur  
Trainee Clinical Psychologist  
Child and Adolescent Mental Health Service  
Royal Edinburgh Hospital  
Tippelinn Road  
Edinburgh  
EH10 5HF



**RESEARCH & DEVELOPMENT OFFICE**

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Director: Professor Heather A Cubie



Dear Miss McArthur

**LREC ID No:** N/A  
**R&D Project ID No:** N/A  
**Title of Research** *Grounded Theory Study of Recovery in Child Sexual Abuse - Exploration of Perceptions and Clinical Work of Clinicians.*

Further to recent correspondence, we note that this project is now considered to be audit/service development, therefore, will not be followed through further by the R&D Office.

Yours sincerely

**Professor Heather A Cubie**  
R&D Director

**Correspondence with local CSA teams to request input about focus of study**

**FAO:            Team**

I have begun my third year specialist placement as a Trainee Clinical Psychologist within the            team under supervision from            . As described at the            , I will be completing a thesis which I am keen to carry out within my elected specialist area of sexual abuse/ trauma. However, I am also keen that any work I complete is relevant and useful to staff working in this area. I became aware of the study carried out by            , which focused on the impact on professionals of working with those who have experienced trauma.

It appears that there might be scope to carry out a follow up study, which further explores some of the concepts generated by the            and takes forward some of the practical applications. It has now been            since            this research was completed therefore a follow up study would allow for exploration of the longer term impact of working in this area. Review of the literature suggests that there is a lack of such longitudinal research in this field. It may also facilitate further exploration of what the particular support and supervision needs are of staff working in this area. I am keen to find out whether there would be any interest in participation in such a study. I would be particularly interested to know whether staff involved in the original study would be interested in participation in a follow up study.

I was however aware that completion of a follow up study may not be possible and I have therefore created four research proposals in total for consideration by staff groups, three of which relate directly to CSA. I have outlined the possible practical outcomes which may be produced as a result of the research and the input which it would involve from staff. I presented these four options to our            today and we have agreed to discuss these options in the coming week. I have therefore attached these four research proposals in order that the wider CSA team network may consider them and I may be able to gauge interest in the proposals.

If there is interest, I would be very keen for feedback via email or telephone regarding which proposal staff feel would be most relevant or useful for their team if possible by            Please feel free to email me or make contact at the address listed below.

Many thanks for your time in considering this study.

Yours sincerely

Lorna McArthur  
Email: [Lorna.McArthur@lpct.scot.nhs.uk](mailto:Lorna.McArthur@lpct.scot.nhs.uk)

Work Tel:

**Initial proposal for consultation**

**Proposal 3**

**What does 'recovery' in CSA mean?**

**Two main themes:**

**APPROACHES CURRENTLY USED:** Reflections on what 'recovery' in CSA means. How clinicians conceptualise recovery or progress. What are the barriers/blocks to recovery?

**CHANGES TO APPROACHES USED:** How has experience impacted on approaches used? Use of varying team approaches.

**Exploration of themes may include:**

- What does recovery mean? How can it be identified? What are the common barriers/blocks to recovery?
- How do you help people/what makes the difference?
- Reflections on changing therapeutic approach over time.
- How has your style of working impacted on you?
- How does the reality of therapy contrast with training provided/theoretical frameworks.

**OUTCOMES PRODUCED FOR THE TEAM**

- Compile a summary of current thinking/recent research in the area of recovery in CSA.
- Findings of the research to be disseminated in full to the team.
- Practical applications/recommendations will be considered and reflected back to all staff who participated.

**INPUT FROM THE TEAM**

Approximately 10 members of the CSA network team to take part in one in depth interview (Maximum duration 1 ½ hours).

**Participant Information Sheet**

I would like to invite you to take part in an evaluation study. Before you decide you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. Talk to others about the study if you wish. Part 1 tells you the purpose of this study and what will happen to you if you take part. Part 2 gives you more detailed information about the conduct of the study. Please ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

**What is the background to this research?**

There is considerable variability in how and to what extent children are affected by sexual abuse (Chaffin, Wherry & Dykman, 1997). As a result it would seem that the nature of recovery in this client group and therapeutic interventions required may be equally varied. Recent research suggests that CSA constitutes a systemic problem which requires multiple levels of intervention and therapies across developmental life stages and involving more than the survivor in isolation (Jones and Morris, 2007). In recent years there has been an increase in research in the area of resilience and recovery. Despite growth of this research there has been less focus on how child sexual abuse teams currently conceptualise and facilitate the process of recovery.

**What is the research aim?**

The aim of this research is to increase our understanding of the nature and form of recovery following child sexual abuse, drawing from the experience of staff employed within CSA services.

**What methodology will the study use?**

Staff currently working within \_\_\_\_\_ will be invited to take part in one in-depth interview regarding the topic of recovery. The study will use the qualitative research methodology of Grounded Theory. Data will be gathered through interviews and hypotheses regarding the nature of recovery in CSA will be generated from this material. Qualitative methods assume that individuals themselves are experts as regards their own experiences. This material alone is therefore used to generate hypotheses, rather than restricting data collected by using standardised questionnaires.

**Who will be invited to take part?**

Approximately ten members of staff from \_\_\_\_\_ will be invited to take part. Staff who currently work with children or young people who have been sexually abused will be interviewed. This is because this research question relates to recovery amongst those who have experienced sexual abuse.

**How long will the interview last?**

Interviews are expected to last for approximately one hour.

### **Who will carry out the interview?**

The interviews will be carried out by Lorna McArthur who is a final year Trainee Clinical Psychologist currently working within . The interviews and subsequent analysis of this material will form the basis of her doctoral thesis.

### **What questions will I be asked?**

Qualitative approaches assume that individuals themselves are experts as regards their own experiences, therefore the interview will be guided by the contributions of each participant. A set series of questions will not be used.

The key theme which will be explored within each interview is:  
Can you describe your understanding of recovery in CSA?

Other possible areas of interest include:  
How can recovery be identified?  
How do you facilitate recovery after CSA?  
Are there any barriers to recovery?

### **Where will the interview take place?**

Interviews will take place at .

### **How will the confidentiality of the interviews be ensured?**

All interviews will be recorded. These audio-recordings will be stored in a locked NHS filing cabinet. Only Lorna McArthur and her supervisor will have access to these recordings. The interviews will be transcribed and all identifiable personal details will be removed or altered to protect the participant's anonymity. Recordings will then be destroyed. Qualitative research involves quotation of direct excerpts from interviews to give examples of themes which emerge. However, any quotations will be made anonymous.

### **Will I be able to withdraw from the interview?**

Participants may withdraw from the interview at any point regardless of the fact they have given consent and without providing an explanation for this withdrawal.

### **Will I be able to discuss this research with anyone not involved in the research?**

Lorna will ensure that the supervisors of each participant are aware of the research aims and objectives in order that participants may discuss their involvement and any related issues during their own supervision sessions.

### **What will happen to the research findings?**

The findings from this study will be fed back to all the teams who participated in the study and to the . Lorna will conduct a review of current literature in the area of recovery in CSA. This review will be made available to each of the teams who participate in the study. Lorna will give regular updates to about the progress of the research. This will allow for continual input and discussion amongst members of . It is

hoped that that through this process the research will remain relevant and meaningful to those individual therapists who form

**What do I do if I have any questions or if I would like to take part in this study?**

Please contact Lorna McArthur by telephone on \_\_\_\_\_ or by email at [lorna.mcarthur@lpct.scot.nhs.uk](mailto:lorna.mcarthur@lpct.scot.nhs.uk)

Lorna will then meet with you to answer any questions you may have about the study. Prior to taking part you will be asked to give informed consent, however you will retain the right to withdraw from the study at any point.

If you would like to discuss the research with someone not involved please contact your team supervisor who will be aware of the study and may be able to answer your query or may contact Lorna to pass on this query.

**MANY THANKS FOR YOUR TIME IN CONSIDERING THIS STUDY**

Table 2: Central category carried forward during interviews

| Category                        | Sub-Category                    | Participant Number |    |    |    |    |    |    |    |    |     |     |     |
|---------------------------------|---------------------------------|--------------------|----|----|----|----|----|----|----|----|-----|-----|-----|
|                                 |                                 | P1                 | P2 | P3 | P4 | P5 | P6 | P7 | P8 | P9 | P10 | P11 | P12 |
| <b>Unique, evolving Journey</b> | Unique journey                  | ✓                  | ✓  | ✓  | ✓  | ✓  | C  | C  | ✓  | C  | ✓   | ✓   | C   |
|                                 | Evolving journey                | ✓                  | ✓  | C  | ✓  | ✓  | C  | ✓  | ✓  | C  | ✓   | ✓   | C   |
|                                 | 'Getting back to being a child' | ✓                  | ✓  | ✓  | ✓  | ✓  | ✓  | ✓  | ✓  | C  | ✓   | ✓   | C   |
|                                 | Length of the journey           | ✓                  | ✓  | C  | C  | ✓  | C  | ✓  | ✓  | C  | C   | C   | C   |

Key

✓ = sub-category mentioned spontaneously by participant; C = sub-category carried forward through reintroduction by interviewer.

**Table 3: Categories carried forward during interviews**

| Category                               | Sub-category                             | Participant Number |    |    |    |    |    |    |    |    |     |     |     |   |   |
|--|--|--------------------|----|----|----|----|----|----|----|----|-----|-----|-----|---|---|
|  |  | P1                 | P2 | P3 | P4 | P5 | P6 | P7 | P8 | P9 | P10 | P11 | P12 |   |   |
| <b>Building safety and trust</b>       | Establishing safety                      | ✓                  | ✓  |    | C  | ✓  | ✓  | ✓  | C  | ✓  |     |     |     | C | C |
|  | Being believed                           | C                  |    |    | ✓  | ✓  | ✓  | ✓  | ✓  | ✓  |     |     |     | C | C |
|  | Building trust                           | ✓                  | ✓  | ✓  | C  | ✓  | C  | ✓  | C  | ✓  |     |     |     | C | ✓ |
|  | Gaining insight into emotions            | C                  | ✓  | ✓  | ✓  | ✓  | C  | ✓  | ✓  | ✓  |     |     |     | C | ✓ |
| <b>Integrating the experience</b>      | Telling the story                        | ✓                  | ✓  | C  | ✓  | C  | C  | C  | C  | ✓  |     |     |     | ✓ | ✓ |
|  | Acknowledging loss                       | ✓                  |    |    | ✓  |    | ✓  | C  | ✓  | ✓  |     |     |     | C | C |
|  | Meaning making and integration           | ✓                  | ✓  | C  |    | C  | ✓  | C  | ✓  | ✓  |     |     |     | C | C |
|  | Acknowledging what has happened          | C                  | ✓  | ✓  | ✓  | C  | C  | C  | C  | ✓  |     |     |     | ✓ | C |
| <b>Building familial relationships</b> | Parents /carers working through emotions | ✓                  | ✓  | ✓  | ✓  | C  | ✓  |    | ✓  | ✓  |     |     |     | ✓ | C |
|  | Gaining acceptance                       | ✓                  | ✓  | ✓  | ✓  | ✓  | C  | ✓  | ✓  | ✓  |     |     |     | ✓ | ✓ |
|  |  |                    |    |    |    |    |    |    |    |    |     |     |     |   |   |

Key: ✓ = sub-category mentioned spontaneously by participant; C = sub-category carried forward through reintroduction by interviewer.

Appendix 7 continued

Table 3 continued: Categories carried forward during interviews

| Category                          | Sub-category                       | Participant Number |    |    |    |    |    |    |    |    |     |     |     |   |   |   |   |   |
|-----------------------------------|------------------------------------|--------------------|----|----|----|----|----|----|----|----|-----|-----|-----|---|---|---|---|---|
|                                   |                                    | P1                 | P2 | P3 | P4 | P5 | P6 | P7 | P8 | P9 | P10 | P11 | P12 |   |   |   |   |   |
| <b>Finding self worth</b>         | Increasing 'sense of self'         | ✓                  |    | ✓  | ✓  | ✓  | C  | C  | ✓  | C  | ✓   |     |     |   |   |   | ✓ | C |
|                                   | Increasing confidence & self worth |                    | ✓  | ✓  | ✓  | ✓  |    | ✓  | C  | ✓  |     |     |     |   |   |   | ✓ | C |
| <b>Re-engaging with the world</b> | Shift in priorities / interests    | ✓                  | ✓  | ✓  | ✓  |    | ✓  | ✓  | ✓  | ✓  | ✓   | ✓   | ✓   | ✓ | C |   | ✓ | C |
|                                   | Re-engaging with relationships     | ✓                  | ✓  |    |    | ✓  |    | ✓  | ✓  | ✓  | ✓   | ✓   | C   | ✓ | ✓ |   | ✓ | C |
|                                   | Moving on from therapeutic support | ✓                  | ✓  |    |    | ✓  |    |    |    |    |     | C   | ✓   | ✓ | C | ✓ | ✓ | ✓ |

Key: ✓ = sub-category mentioned spontaneously by participant; C = sub-category carried forward through reintroduction by interviewer.

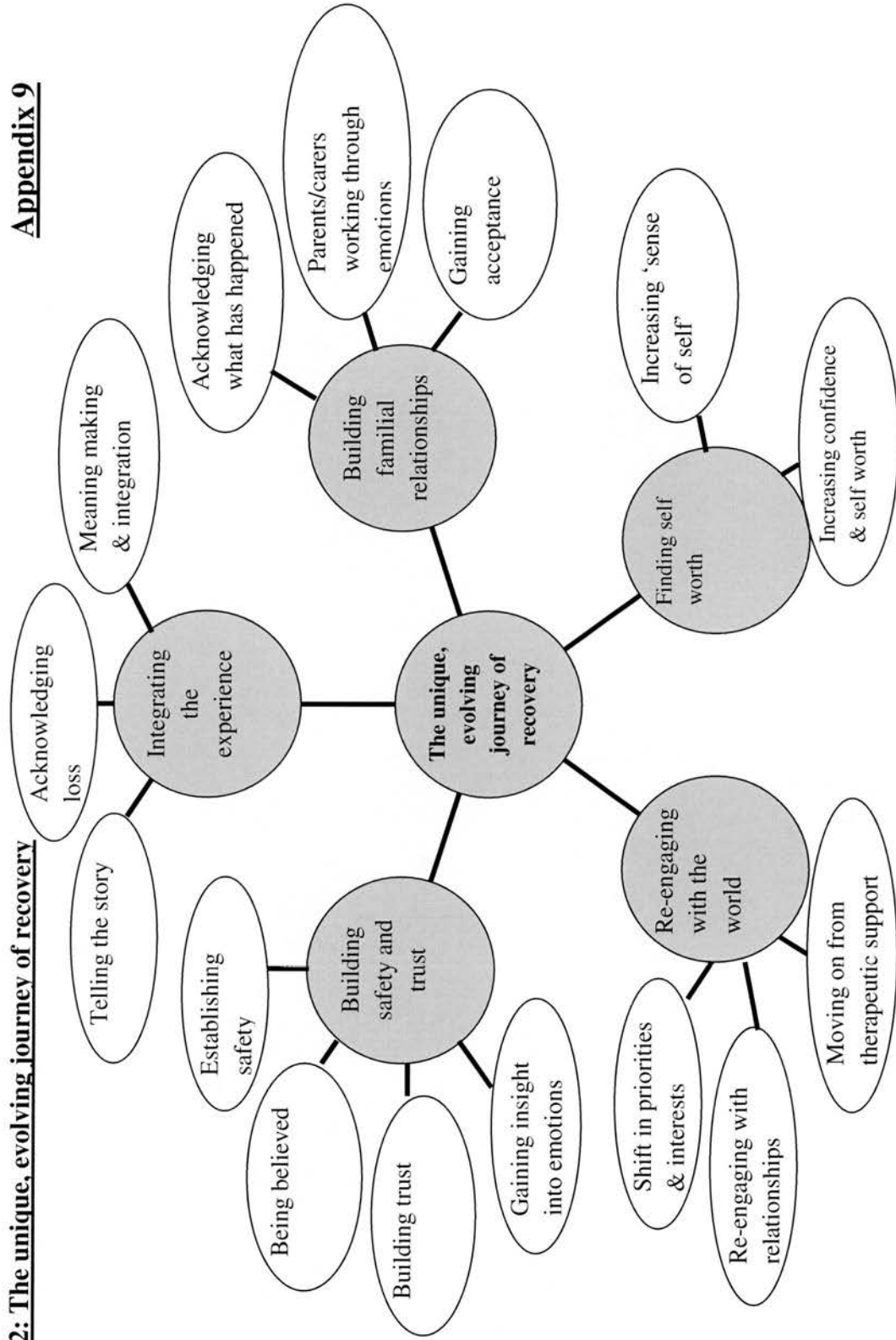
**Table 4: Additional category carried forward during interviews**

| Category              | Sub-category mentioned by each participant |    |    |    |    |    |    |    |    |     |     |     |
|-----------------------|--|----|----|----|----|----|----|----|----|-----|-----|-----|
|                       | P1   | P2 | P3 | P4 | P5 | P6 | P7 | P8 | P9 | P10 | P11 | P12 |
| Concerns about stigma | ✓  | ✓  |    | C  | ✓  | C  | C  | ✓  | ✓  | C   | C   | C   |

**Key**

✓ = sub-category mentioned spontaneously by participant; C = sub-category carried forward through reintroduction by interviewer.

**Figure 2: The unique, evolving journey of recovery**



**Appendix 9**

**Additional category:**

**CONCERNS ABOUT STIGMA**

This additional analysis relates to concerns about stigma which permeated all narratives. Clinicians expressed a strong desire to avoid using any language or labels which may leave children or young people feeling stigmatised.

Many clinicians expressed concerns about use of language which they viewed as 'medicalised'.

*'I think it would, I think I would still have difficulties with the word because I, I suppose 'recovery' comes from a medical language doesn't it, and it's like, you, you have an illness and you recover from it' (Participant 11)*

*'I hate the word 'symptoms' as well, what they're experiencing (...) I don't think you want to medicalise something that is actually a dreadful thing to happen.'* (Participant 1)

Some clinicians stated that use of use of certain terms such as 'recovery' may not be appropriate at earlier developmental stages as children may make erroneous assumptions about the meanings of those terms due to their cognitive capabilities. For example, some expressed concern that the word 'recovery' implied a process which incorporated an inevitable finite end point at which difficulties had been overcome. Given consistent view amongst clinicians that recovery is an ongoing process, this resistance appeared understandable.

A number of clinicians also expressed their discomfort with use of terms commonly found within adult literature such as 'survivor' and processes of 'healing'.

*'I don't like the word survivor either (mm-hm) somebody who's 'survived' sexual abuse' (Participant 3)*

In describing their resistance to such language commonly used within adult literature Clinicians reflected that adults who chose to describe themselves with terms such as

'survivor' were more likely to have made an informed choice to do so. However, they felt uncomfortable with using such terms with children or young people whose identity was still early in process of forming.

*'in some way there is something about putting an issue to bed or to rest as an adult that has a different kind of context of finality about it, in the way that feels uncomfortable in, in, in terms of talking about it with a child or about a child because you know that they're just so young in their, in their ability to kind of make meaning or ehm the choices that they're going to make in their life' (Participant 12)*

As a consequence many clinicians felt that language or labels should not be imposed upon children or young people but rather they should be allowed to choose for themselves how to describe themselves and their experiences.

Clinicians' descriptions of recovery in clinical practice were very similar to descriptions found within current adult literature. However, these child and adolescent workers expressed particular concern about 'imposing' language or labels upon children and young people. Consequently, they expressed resistance to describing recovery with the language adopted in current recovery literature. This appeared driven by their desire to avoid stigmatisation. A tension therefore emerged between recovery as seen in clinical practice, how they chose to describe it.

**Sample except from reflective diary**

*Interview 6 – 18<sup>th</sup> April 2008 - Notes written directly after interview*

Very psycho-dynamically minded person. Big difference to last interview. Surprised by the contrasts between approaches of staff in the same team – do they have different views on recovery or are they just coming from different backgrounds?

More practical approach at first – described what actually happens in the room with therapist & the differing roles of therapists.

POINT OF INTEREST? - he discussed child ‘putting him in roles’ i.e. “Becoming a ‘baddy’ in play with the child”, letting that happen, very different type of approach from last two interviews. Tension? Between clinicians who use very directive approaches/goals etc vs this more non-directive ‘creative’ approach? Both approaches represented within teams – clash of therapeutic styles or complimentary?

Today – he talked about recognising recovery, signs like repetitive play would reduce and ‘healing’ play would be seen, puppets getting better, mending toys, SYMBOLIC? play with new themes?

CONTRAST - Others very unhappy with phrase ‘healing’ – differences in language emerging between individuals or therapeutic backgrounds?

Described power dynamics – children will try to “deceive” you, to see your reaction. Will try to “trick you, fool you”, “it’s about power”. He feels comfortable with being “cast” in a role so children can work through repetitive play. Does he feel tension of others too about not mirroring negative power dynamics in therapy vs letting free play happen?

PERSONAL INFLUENCES - acknowledged own biases & reasons for that, talked about ‘hating’ psychiatry even although psychiatric nurse.

PHASES OF THERAPY – uncomfortable, feeling lost (I associated with that uncertainty from my own clinical work)

CHILD ‘STUCK’ - Talked about seeing recovery as child ‘stuck’ in certain part of developmental process so your job as therapist to help them get back to that stage then flow through the stages. But didn’t see himself as ‘leading’ that. Child leads it.

CONFLICTING NARRATIVE – talked about the fact people might be able to recover in one part then conflicted self in saying that “abuse never leaves you – lasts a life time” so you never fully recover.

LANGUAGE - Discussed his unsure feeling about using the word 'recover' as implies it will all get better, Didn't like the word 'symptoms' and discussed why. Relates to his own personal experiences and his work experience. Both seem enmeshed as he talked about the two interchangeably.

PARENTING also highlighted. Bits in the interview where I was trying to pick away at difficult topics, made it more tricky at times, my anxiety went up when he wasn't sure what I was asking but also he then talked about quite interesting aspects of the work. His attitudes to psychiatry and medical model. Discusses the fact 'symptoms' locates the 'problem' within the child, also said that language reflects a huge power imbalance, he tried to address that so as not to mirror the power imbalance of the abuse.

STRONG FEELINGS EXPRESSED - 'Symptoms - demeans the person, the soul', strong language. CAMHS problems with this service, 'we are the experts?' message given to child, power imbalance? Is it the child who can lead us to what recovery should mean? Do we have the right to go in as the all seeing all knowing professional? He reflected resistance to psychodynamic therapy, "they don't want to be psychoanalysed".

STIGMA - Coming to a hospital, to 'mental health' service, power is with the staff at the outset. If people are giving messages about symptoms reduction etc to the kids, will they implicitly locate the problems as within themselves? Discussion of power issues. How to try to re-dress these, noted that the CAMHS service instantly has the power. (I have often wondered how it must feel for young people being seen in a hospital. Resonate with these concerns from my own clinical practice)

### **Personal Reflections**

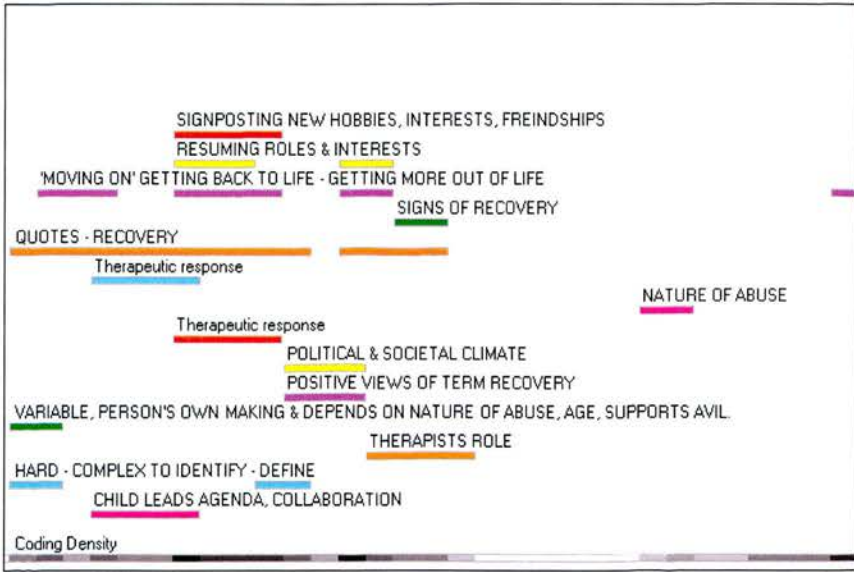
I associated with his feelings of uncertainty about the "endpoint" of recovery. Reassuring for my own clinical work that experienced clinicians still feel this. Feeling lots of uncertainty in placement about whether I'm providing "good enough" therapy for CSA. Children/young people already experience so much – the stakes feel high. Used advice from supervisor to try and be more relaxed/less formal. Struggle with this as am interviewing colleagues. I was surprised by the strength of reaction about language, very strong reaction to symptoms. Is this a personal view affected by personal experience or does it also reflect desire to be "child centred"? Not labelling child? Felt more confident to follow up some trickier questions. Quite anxious because he seemed to struggle to find some answers – found it hard to keep prompting in these more difficult areas instead of moving onto 'easier' topics but once I did he reflected on very interesting material about his own life experiences. Need to be more confident in trying to ask the more difficulty questions – "does recovery happen?" "what actually happens in the room to facilitate this?" Helpful following asking me to follow that up a bit.

**Sample of interview transcripts – Interview 1**

Interview 1 - Transcript

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Right, it's huge actually, it's, my understanding of recovery is also so different for every young person I meet I think, do you know? (mm-hm) I think recovery is what they feel, they can go out and get on with the bits of their life that they want to get on with again do you know? I never get a, I always I think you know the more experienced I've become in this it's more so about asking the young person what do they see as they want (OK), how would they know that things are a bit better and that they can get on? So it's something about getting back out there and living the bits of their lives whether it's about going to school or college or work you know managing the family life (mm-hm) and having a quality of life that they feel they're getting back to that's, that, that they want you know. Oh recovery is so, I knew when you asked me that it's just such a big thing (mm-hm) and there's just so much about it now with the recovery network and all that kind of thing for maybe more longer and enduring stuff (mm-hm) but I just think for these young people there's something about them just getting back to their bits of their life that they want to take up again (mm-hm) that it feels like they've got a bit more hope and that they feel that they can achieve what they want to achieve if that makes sense?

**That's very helpful and actually in that you've described a few different parts so I wonder if I might just (mm-hm) ask you about each of the different bits that you've mentioned. You talked about managing family life (uh-huh) could you tell me a wee bit about what might change in their management of family life or what that might involve?**

Well all I mean I think if the CSA is famil inter-familial (mm-hm) I think that makes a huge difference and I think, I mean, we've all, I suppose I've always worked with the non-abusing parents and it's interesting hearing more stories around from even the people who work with younger children working with their non-abusing parents as well (mm-hm) but I suppose for these young folk, family life it just can absolutely be devastating (yeah) do you know, for them if they've disclosed initially if they eventually disclose and it is whether it's step father or father I think that makes a huge difference (mm-hm) and I think that's when you have to be in other circumstances.

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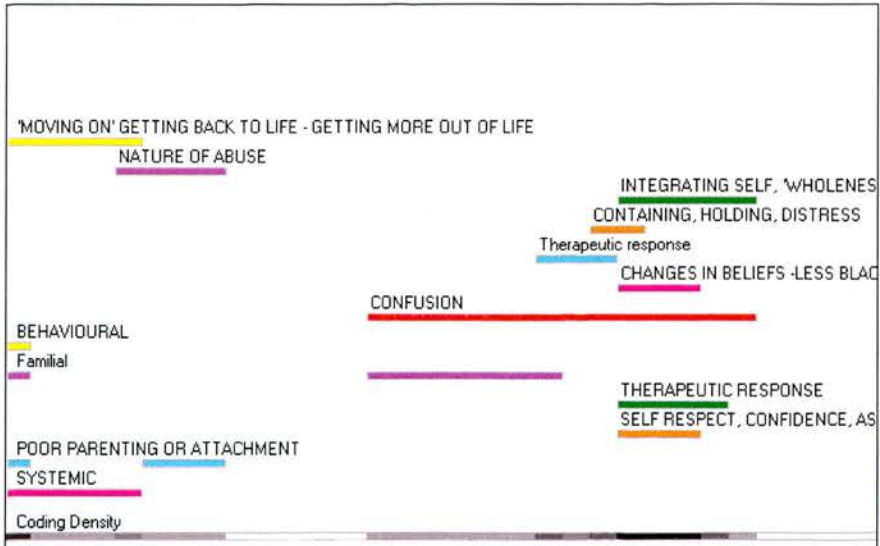
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Interview 1 - Transcript

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difference (mm-hm) ehm and I think that's when you have to bring in other supports too whether there's individual work with the young person involved but there has to be somebody meeting the other members of the family too (mm-hm) the other sort of non-abusing carers to look at pulling this back together and how can they get back on track to being a family again. I think as well when it's out-with the family it's devastating (yes) if parents or carers hear that they've not protected (mm-hm) and they feel that they've not protected their child and you need there needs to be work around that as well ehm.

**If we first go into the part you were what you said there about inter-familial incidents are there's a "huge" difference (mm-hm) I think that was the phrase you used (right) can you tell me a wee bit about that (elun) the impact of that?**

I think maybe huge difference is too big but I think there is a, but you know having worked with I suppose slightly older young people if that makes sense (mm-hm) it's not children it some of the work when you work with these usually young woman and it has been for me is their need to work out and understand the confusion around having whether it's their dad or step-dad that they've had for years who is their one of their main carers and who is also the abuser (mm) and how they can work out all those feelings around that and I think one of the things I'm really aware of now is me not presuming about how they're going to feel about that person (OK) cos they have to tell you how they feel and their confusion and I think you're there to help them work out the feelings around it (mm-hm) and you hope getting to a point that they can see that the behaviour was completely unacceptable and not OK and it's not about their fault but it's also OK to still have feelings for this person (mm-hm) that they that in other ways maybe did care for them and was there you know, ehm so that's, that's a big thing. I. I think that work's really important actually (mm-hm) eh.

**And you talked about "working out" the feelings and these confused feelings elun and in the process of recovery what form does that take or how do you work with that, "working out" these feelings?**

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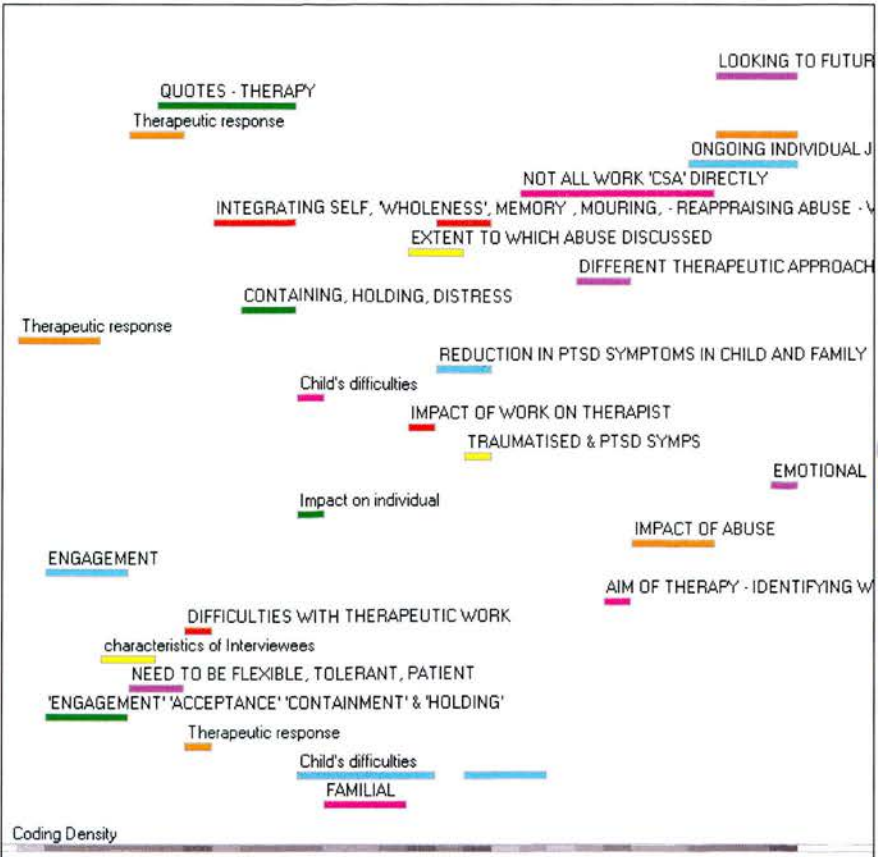


Interview 1 - Transcript

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As in with in the CSA young people? (yeah) [exhales]... ((3secs)) I think it can take longer (OK) an I think it can I think it can definitely take longer. I think sometimes the engagement process can be longer too because there are huge issues of trust (OK) in maybe whatever's happened to them ehm and I think you can, I mean this can be with a lot of young people too, I think you can take so many steps forward but then there's often steps back as well (right) ehm because you know what we, what I'll find you do often say with these young people, and is it really hard, they might feel worse initially cos you're asking them to face on what's happened to them and (m-m-hm) bring it into this room or into this session or whatever ehm and in some ways trying to relive it in a safe way you know in a safe place that they can sort of know they can manage it... ((2 secs)) I mean I think, an this isn't always the way but a lot of these young people too, you know CSA's only a part of what they're coming for (m-m-hm) you know even if they have, there's the non-abusing carers there there's often so many other things sometimes going on if there's just all this blooming adversity in their life that the CSA's one part of it and I'm somebody, I know this, that I struggle with OK we can see that their symptoms are less which often aren't there for that long sometimes you know but there's PTSD symptoms (m-m-hm) but life's still shit excuse the language [laughs] (yeah) do you know and you can see the other bit the knock on bits of that that I sometimes struggle just to ehm keep my work to that CSA but I think when you work with these young people you have to take in the picture you know (OK) the whole does that make sense (it does) the whole picture I think. Some people work differently to that. I struggle to separate that out I think when you're working with this young person you have to listen to what else is happening (m-m-hm) cos the CSA may just be triggering other things that have happened before too or are happening now do you know?... ((2 secs)) Ehm so I think it, I think recovery for these young folk can be a longer process I also think sometimes when you finish off with these young people I would always say that you may feel that in the future you want to come back to some things too I think it can be with you for a long long time ehm.

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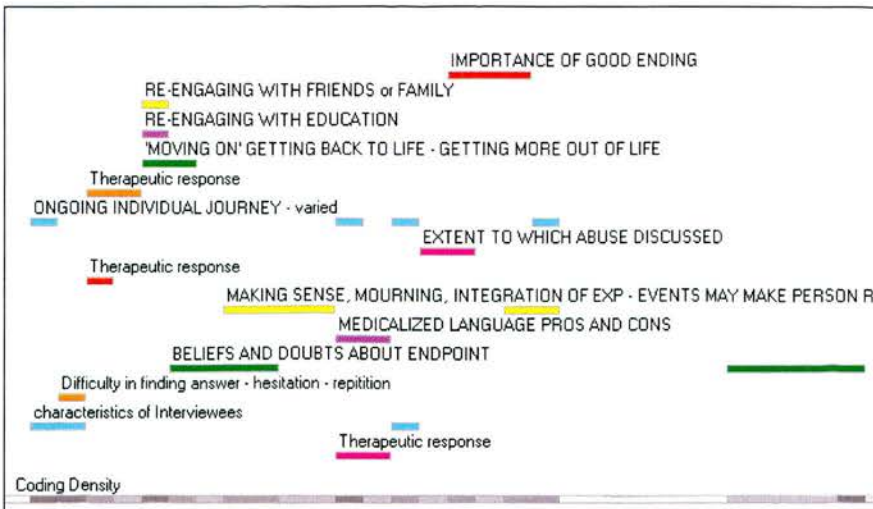
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I still think it's ongoing. I think we somehow and you're going to ask me how we think we get to that stage [laughs] which is going to be really hard for me to answer, eh I think you get to certain stage and whether that's together, what I'd hope when you meet the young person initially is what would they like to be different you know whether it's school getting school back getting friends back getting that (mm-hm) *life* back so they feel that whether they've got these things back... ((4 secs)) gosh, there's not often I feel, these, it recovers, see I never know if recovery is complete I think that's really, I think when you've had something like this happen to you there's always going to be dips again that where there're things that trigger it again maybe not as severely as it has been (yeah) but I think it's with you and I think it's part of your life history there'll, there'll be certain stages it it maybe comes back again and and how you manage that so... ((2 secs)) I think quite a bit of it's ongoing (mm-hm) I usually, I suppose I usually do use those words with most of the young people I see is, and I hate, and I know folk find this really naff, but it's more like a journey that you know your (mm-hm) this is the bit we've got, you know, whether the the sort of the low mood the symptoms they were experiencing are sort of a bit better (mm-hm) but you know you're trying to equip them for when you, you do fin- you know finish with each other that things may trigger it again and (mm-hm) a lot of it is about identifying triggers and what happens you know but I think it often quite ongoing actually (mm-hm).

And just thinking on it in that way would you expect that to be something that would ever have an end point or do you feel... ((2 secs)) in terms of recovery (yes) that it's across the life-span for these young people?

... ((4 secs)) I would hope that it would somewhere whether that you know [exhales] whether they get to a stage and the life that they've helped to build for themselves holds them and just gets them through that I would hope that there is recovery actually, I would yes, and I think in my head there is. I mean most young folk I think I do feel a lot of hope for, I think you often have to carry the hope initially and

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