What Influences Women with Sexual Assault PTSD to Disengage from Therapy?

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Abstract

Title

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Background

Approximately 20% of clients disengage from mental health psychological therapies for PTSD in the UK, irrespective of mental health providers in primary care, secondary care or third sector mental health services. Regardless of treatment approach, therapeutic model and developments in specialist psychological therapy approaches, high rates of client disengagement remain across all mental health services for PTSD therapy. It will be seen that no one modality is optimal for the treatment of PTSD. Research and development of trauma-focused models of psychotherapy indicates that client disengagement remains problematic even in these recommended therapeutic approaches. Furthermore, research to reduce rates of disengagement from PTSD psychotherapy predominantly focuses on the client, that maintains a negative view by placing the burden of disengagement on the client.

Aim

The practical aim of the research is to inform and discover those influences for women who received psychotherapy for PTSD from sexual assault, and who disengaged. This research attempted to address this by asking clients directly why they disengaged from psychotherapy before completing the recommended number of sessions assessed.

Methods

The methods for this thesis question was addressed by qualitative exploration of the experiences of four participants who had received psychotherapy at a UK based counselling charity for women, for sexual assault PTSD. The charity offers psychotherapy sessions for PTSD that is focused on the specialism of sexual violence. Participants were aware from the outset the number of psychotherapy sessions offered, established at assessment. Participants were interviewed using a semi structured audio-recorded interview covering ten questions about the participants experience of therapy and the reasons they disengaged. Interview data were qualitatively analysed using interpretative phenomenological analysis (IPA) to learn about the participants experience, from their perspective.

Results

The findings revealed potential influences that persuade participants to disengage from therapy for sexual assault PTSD, before any noticeable improvement in their mental health and wellbeing. The findings of this research calls attention to: 1) the paucity of research for client disengagement that uses actual client accounts 2) the paucity of research for psychotherapy models that are effective for the treatment of sexual assault PTSD beyond that of symptom reduction, that emphasises quality of life and wellbeing 3) the ubiquitous and prolific presence of medical model approaches that dominates research for psychotherapy treatment modalities for PTSD 4) the paucity of delineation of differential trauma types and psychotherapy research for PTSD 5) the impact of the therapeutic relationship on disengagement from psychotherapy for sexual assault PTSD, and finally, 6) therapist effect and impact on disengagement.

Conclusion

Each of the four women in this study shared their experience of a therapy that failed them. Future research for effective therapy models for PTSD without attending to therapist effects and the centrality of the therapeutic relationship will likely bring the same results for disengagement, from across all therapeutic modalities. Research for non-trauma focus treatment approaches for PTSD, though scant, continues a long-held

focus on client deficits for disengagement. Therapeutic outcomes from qualitative research that measure for example, therapist effect, therapeutic relationship, and successful rupture resolution, is the next imperative in research, to redress the balance of research available for disengagement from sexual assault PTSD in non-trauma focus treatment approaches.

Further research into those therapeutic process influences that induce clients to disengage from therapy is crucial for advancing our understanding of client-therapist patterns of relating, the interpersonal and attachment patterns of the therapist, and the skills and experience the therapists bring to therapy that sustains a client to completion of therapy treatment. The therapeutic relationship is a collaborative dyad: two individuals working towards the same goals for the client's wellbeing.

Key words

Adults, women, sexual assault, PTSD, psychotherapy models, disengagement.

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Abbreviations

Trauma Focused Therapies (TFT)		Non-Trauma Focused Therapies (Non-TFT)	
CBT	Cognitive Behavioural Therapy	**Dialogical Therapy**	Dialogical Therapy (also called dialogical philosophy and dialogical theory)
Cognitive Restructuring	Cognitive Restructuring	**Emotion Regulation Skills Training**	Emotion Regulation Skills Training (also called Emotional Regulation Therapy)
CPT	Cognitive Processing Therapy	**Gestalt Therapy**	Gestalt Therapy
CT	Cognitive Therapy	**IPT**	Interpersonal Therapy
DET	Dialogical Exposure Therapy	**MBSR**	Mindfulness Based Stress Reduction
EBT	Evidence Based Treatment	**PCT**	Person Centred Therapy (also called Present-centred and Client-centred Therapy)
EMDR	Eye Movement Desensitisation and Reprocessing	**PDT**	Psychodynamic Therapy
EST	Empirically Supported Treatment	**RT**	Relaxation Therapy (also called Therapeutic Relaxation)
FAP	Functional Analytic Psychotherapy	**Yoga**	Yoga
IE	Interoceptive Exposure or Imaginal Exposure		
MCT	Metacognitive Therapy		
NE	Narrative Exposure		
PC	Progressive Counting		
PE	Prolonged Exposure		
RCT	Randomised Controlled Trial		
SIT	Stress Inoculation Therapy (also called Stress Inoculation Training)		
TI-MBSR	Trauma-Informed Model of Mindfulness-Based Stress Reduction		

Chapter One

Introduction

Chapter Overview

This Chapter introduces the research study that will explore the experience of therapy for women presenting with symptoms of post-traumatic stress disorder (PTSD), who have experienced sexual assault, and why they took the decision to disengage from therapy. This Chapter is divided into six sections. Section one presents the rational for the study; client disengagement from treatment generally, and the measures and methods in current research studies that have been developed in an attempt to reduce rates of disengagement from therapy. The development of trauma-focused treatment (TFT) and non-trauma focused treatment (non-TFT) approaches for PTSD and disengagement are outlined in sections two and three. Section four explores sexual assault and PTSD in context, and section five outlines the author's positionality within the research study; the conceptual framework and the purpose of the study, including the research questions. Section six outlines the structure of the study Chapters, and the final section concludes the introduction Chapter for the study. The charity is referred to as the Women's Service (WS) throughout this study. The feminine pronoun in generic references to therapist and client, is also used throughout. TFT and non-TFT therapy terms and definitions, including a brief description, is provided in Appendix 1. Psychodynamic therapy (PDT) and defence mechanism terms and definitions are provided in Appendix 2 and 3, respectively.

Rationale for the Research

In 2012, an informal internal audit[1] (charity, 2012) was authorised by the manager of a third-sector charity[2] therapeutic service. The purpose of the audit was to establish

[1] Informal reviews and audits are generally much smaller and performed on an ad hoc basis for continuous quality improvement and professional development (Jamtvedt, Flottorp and Ivers, 2019).
[2] For confidentiality, I am unable to name the mental health service.

clients' engagement with therapy. The audit raised a number of concerns, namely, that clients were disengaging from therapy without completing the number of therapy sessions outlined in the initial assessment for therapy.[3] The aim of the audit was to determine the average number of therapy sessions engaged in by women who accessed the service, with data collected from 93. Results of the audit showed that:

- 24% (22 of 93) of clients engaged in less than five therapy sessions, and
- 41% (38 of 93) of clients engaged in less than 10 therapy sessions.

These figures show that by the 10th session, 65% (n=60) of clients disengaged from therapy earlier than planned, and half of the clients (n=46) did not complete the agreed number of sessions, as recommended in the initial assessment.

In the UK, a significant percentage of therapy treatments are prematurely terminated because clients disengage from treatment (Swift et al., 2012). Approximately 20% of all clients disengage from treatment early, with higher rates among some types of clients and in some settings (Swift et al., 2012, pp. 380). The reasons for this vary widely and precise motives are difficult to determine, differing from one client to another (Barrett et al., 2008).

The majority of research identifies client disengagement as a failure of the client to continue therapy beyond a set number of sessions or duration of treatment (Hatchett and Park, 2003). The basic tenet is that in order to effect any desired therapeutic change for a client, a minimal number of sessions need to be attended. Historically, it is accepted that if a client attends regular therapy sessions (Lambert, 2013)[4], symptom improvement will be greater over the course of treatment (Lambert, 2013, pp. 204):

[3] In 2012, the WS offered between six and 46 weeks of therapy. The number of therapy sessions is determined at initial assessment by complexity of presentation, criteria for risk and severity of presenting symptoms.

[4] Lambert's (2013) influential resource suggests substantial benefits from treatment occur in relatively short durations (e.g., 14 weekly sessions), and that these gains are maintained over substantial periods of time.

> "*Therapy is highly efficient for a large minority of clients, perhaps 30% of whom attain a lasting benefit after only three sessions...* when monitoring for *reliable improvement... it appears 50% of patients respond by the 8th session and 75% are predicted to need at least 14 sessions to experience this degree of relief*".

Reliable improvement refers to the most widely used assessment measure for therapy outcomes, the Reliable Change Index (RCI), developed by Jacobson and Truax (1991). The RCI is a clinical outcome measure for therapy treatments used to evaluate whether a significant change over time is indicated on individuals' RCI scores. The use of outcome measurements in mental health therapy like the RCI, allows therapists to measure effectiveness of therapy over the course of treatment. For example, when comparing the beginning and end of therapy treatment to determine whether significant change is indicated in a reduction in symptoms. Several alternative clinically significant change measures have been developed since Jacobson and Truax's (1991) RCI to detect meaningful change in individuals' functioning during psychotherapy treatment, which are explored fully in the next section.

Clinical Outcome Measures

Just as therapists use routine measurements to monitor improvements in client symptoms, the quality and effectiveness of mental health services are also monitored with measures such as Routine Outcome Measures (ROM) and Patient Reported Outcome Measures (PROMs) (Roe, Mazor and Gelkopf, 2021). ROM consists of using clients' self-report measures at the beginning of therapy sessions and thereafter, frequently repeated or reviewed over the course of the clients' therapy treatment. The therapist monitors and reviews the treatment; the purpose of which is to provide feedback to therapists and clients on client progress and to provide early indications of client dissatisfaction with the treatment (Shimokawa, Lambert and Smart, 2010, pp. 298-299).

A growing body of research now exists, providing evidence for practicing routine monitoring to measure clinical symptoms, and improving treatment responses and outcomes for clients' psychotherapy treatment (Lambert, 2015). In principle,

measuring, monitoring, and feedback over the course of therapy treatments using clients' self-report measures like PROMs, can reflect changes in clients' responses to therapy and indicate symptom improvement or treatment failure before clients disengage, alerting clinicians to intervene or problem-solve (Lambert, 2015, pp. 381).

Layard and Clark (2014) produced compelling evidence in the treatment and prevention of psychological disorders that emphasised the need for psychotherapeutic or psychological therapy based on evidence gathered by objective measurement tools. Outcome measures that can gauge and evidence individuals' symptom changes and improve treatment can both inform clinical outcomes and improve clinical standards and practice (Kilbourne, et al., 2018). However, Kilbourne et al. (2018) stated that in practice, few studies have linked quality of care process measures to improvements in clients' functioning and clinical outcomes, calling into question the clinical validity of such measures. Moreover, gauging individuals' mental health wellness solely in terms of reduced symptoms is a medical model approach, widely used by psychiatrists and psychologists,[5] and a school of thought that mental disorders are symptoms of an underlying disease that can be treated with therapeutic interventions, and/or including medication. The medical model approach in the treatment of mental illness is fully discussed later in this Chapter, p.18.

Over the last 50 years or more, research has turned its attention on interventions to reduce client disengagement rates from therapy treatments (Barrett et al., 2008). Most comprehensively among these are measures of potential client predictors and variables of disengagement, such as gender, age, socioeconomic status, education, ethnicity, and symptom severity as measures for completion or disengagement in therapy (Barrett et al., 2008). Predictors might signify possible patterns that clients presenting with clusters of such variables are more or less likely to disengage from treatment. For example, van Minnen, Arntz and Keijsers' (2002) study of demographic and clinical predictors of two groups with mixed traumas were analysed for disengagement. Their study findings indicated that substance abuse was related to both treatment outcome and high disengagement rates, but demographic variables

[5] A psychiatrist is classed as a medical doctor and can prescribe medicine; a psychologist is not medically trained and therefore cannot prescribe medicine.

such as depression, general anxiety, anger, guilt and shame were not related to either treatment outcome or disengagement. van Minnen Arntz and Keijsers' (2002, p. 453) asserts that "it is difficult to use pre-treatment variables as a powerful and reliable tool for predicting treatment outcome or dropout".

Whilst there is value in recognising client variables to predict engagement and disengagement from therapy, this thesis shows that client variables do not adequately explain the '*why*' clients disengage from therapy treatment (Swift and Greenberg, 2012). Furthermore, predictors of pre, mid and post therapy treatment variables have not been shown to reduce disengagement rates in psychological therapeutic treatments (Swift and Greenberg, 2012). Indeed, Swift and Greenberg (2012) suggested that by creating a focus on client variables as predictors of disengagement from therapy, in essence, develops a negative view of the client, by stressing the *clients*' predicted characteristics as a definitive explanation for treatment failure.

This type of deficit focus reflects a medical-model approach i.e., 'what is wrong with you?' rather than a therapy-informed approach i.e., 'what has happened to you?' (Sweeney, et al., 2018, p. 319). It will be seen that the medical model approach forms the basis of the literature for the therapeutic treatment of PTSD in Chapter 2 of this study, where much of the available research literature on disengagement from psychological therapies for PTSD fails to engage with clients' accounts of therapy experience and reasons for disengaging, and indeed, where the majority of research outcomes are for populations sampled from mixed PTSD types, from road traffic collisions to domestic violence (Gonzalez, 2016). Moreover, the majority of available research literature is not specific to adult victims of sexual assault. Bisson and Andrew's (2007) study for example, compared TFTs to reduce symptoms of PTSD and found evidence of their effectiveness. However, their study population included war veterans, female sexual assault survivors, refugees and police officers, and mixed groups of individuals who had experienced a variety of traumatic events, including road traffic accidents, assaults, bereavement and industrial accidents (Regehr et al., 2013). Consideration is given to the central position of the client for therapeutic success from different therapeutic approaches for sexual assault PTSD, bringing together a more complete picture of therapeutic disengagement from PTSD (Gonzalez, 2016).

This thesis will show that mental health psychological services have a long history of therapeutic support beleaguered by client disengagement, with many interventions for reducing the number of disengagements proving unsuccessful. It will be shown that despite efforts to address this challenge, clients continue to disengage from mental health services before completing the treatment recommended at initial assessment.

In a broader context, three schools of thought: the medical model, psychodynamic, and humanistic psychotherapy models, provide a background to understanding psychotherapy approaches to PTSD and disengagement; to steer our understanding of the socio-political implications of mental health services that are largely dominated by medical model approaches to PTSD; dominating western European culture that questions the legitimacy and the extent of these models' effectiveness and efficiency for clients presenting with PTSD generally, and in their translation to other, more diverse cultural backgrounds. Specifically, no one psychotherapy approach has been found to be optimal for the treatment of PTSD in research; no distinction of trauma types, such as sexual assault PTSD, is given precedence in research, and recommended psychotherapy approaches continue to be generalised to a one size fits all PTSD classification.

The next section outlines three of the most widely practiced psychotherapy approaches in mental health services, including the development, conceptualisation and implications for the treatment of sexual assault PTSD. The section begins with the historical development of two non-medical psychotherapeutic approaches for the treatment of PTSD: Psychodynamic Therapy (PDT) and Humanistic Psychology. Both models are reviewed in representing a sharp contrast from the traditional medical model approach for the treatment of PTSD, to further our understanding of disengagement. Finally, the medical model is considered, along with some of the implications for its dominating presence within the field of PTSD therapy.

Non-Medical Model Approaches in Psychotherapy

Research studies for mental health and treatment approaches often use the terms psychoanalysis and psychodynamic interchangeably, which can obfuscate their origins. Throughout this study, and for clarity, when the term psychoanalysis is used, it refers to the perspective and theoretical ideas originated by Sigmund Freud (1856-1939). When the term psychodynamic is used in this study, it refers to the ideas and perspective originated by Sigmund Freud, *and* the development and furtherance of his ideas in contemporary theoretical and psychotherapeutic approaches. Of course, convergence and overlap are unavoidable as the genesis of all contemporary psychodynamic approaches are cultivated from Freud's original theories in psychoanalysis, however, it is an important distinction in regard to this study, since the psychodynamic model is central to the author's therapeutic position, and the lens through which this study is reflected.

Psychodynamic Psychotherapy

By the mid-20th century, psychodynamic therapy (PDT) had evolved into multistranded approaches, exploring various elements of the intrapersonal, for example, emotion regulation and the individual's internal efforts to regulate emotions (Rabinovich, 2016). PDT theory and human development have seen for example, the influence of object relations theory on the study of infant-caregiver attachment. Object relations theory focuses on relationships being more crucial to personality development than are individual drives and abilities, originally conceptualised in Freud's psychoanalytic theory of human development[6] (Greenberg and Mitchell, 1983). The key concept of the relational in PDT approaches emphasises relational processes such as relatedness, transference and countertransference between client and therapist, enactment, projective identification and intersubjectivity. However, a common thread shared by all derivatives of PDT is the model of the human mind as

[6] Prototypical theory of Sigmund Freud. Drive theory (also called classical theory) in which emphasis is placed on the libido, the stages of psychosexual child development, and the id instincts or drives. https://dictionary.apa.org/classical-psychoanalysis

conscious and unconscious. Within the conscious mind is everything which we are currently aware of, and within the unconscious mind is a store of everything outside of our awareness.

In PDT psychotherapy the primary focus is on the development of an interpersonal relationship (sometimes called, and used interchangeably, with therapeutic alliance or working alliance), between client and therapist. Emphasis on the centrality of clients' intrapsychic (i.e., ideas, conflicts, and other psychological phenomena that arise in the mind) and unconscious processes, is identified in the clients' defence mechanisms. In order to defend against unacceptable thoughts and feelings, and to maintain beliefs about our past or other preconceived ideas representing some aspect of our world, these defences aid in denying, distorting or maintaining that reality, and may include for example, repression, which is the burying of painful feeling or thoughts from one's awareness, even though it may resurface in another form; projection, in which unpleasant or unacceptable feelings or responsibilities are attributed to others; and rationalisation, the justification of one's behaviour and motivations by substituting 'good', acceptable reasons for the actual (denied) motivations (Freud, 1937; American Psychoanalytic Association (APA), 2022). The goals of PDT therapy are client self-awareness and understanding of unconscious influences from their past on their present behaviour. Recognising and identifying these processes may improve client self-awareness by gaining a new understanding of these behaviours (Bailey and Pico, 2022). Essential to the PDT model is a belief that pathology (i.e., the study of the causes and consequences of psychological disorders), develops in early childhood experiences. Early family interactions (primarily the mother-infant relationship), in personality development is believed to form internal mental representations, or models, that significantly influence interpersonal relationships later in life, which will also emerge in the context of the client-therapist relationship in transference and countertransference processes (Greenberg and Mitchell, 1983).

Transference and countertransference are important processes in psychotherapy since they are the gateway, the intrapsychic language, from which clients' unconscious processes are made conscious. Transference is the redirection of clients' feelings, especially unconscious representations from childhood, towards the therapist; clients view the therapeutic relationship through a subjective lens shaped by past

relationships (Fulmer, 2018). Countertransference is defined as the redirection of therapists' feelings toward the client. Therapists' attunement to their own countertransference is critical to understanding clients' transference, and for avoiding negative transference and countertransference process enactments and re-enactments. (Paul, 2003). Thus, for sexual assault survivors with unresolved or ongoing trauma, therapists' recognition of their countertransference is imperative. Re-enactment in therapy is the process of reliving traumatic events from past experiences and relationships, whilst also re-experiencing the original emotions associated with them in the present, often projected onto the therapist. In the clients' transference re-enactments, the therapist can become her abuser, the unavailable father, the emotionally neglecting mother, etc. Unrecognised and unprocessed re-enactments in the countertransference may lead therapists exposed to a host of destructive, abusive, failed, painful, and neglectful early familial relationships from the client's past (Plakun and Erikson, 1998). Identifying this in the countertransference and interpreting the client's projections toward the therapist can begin the work of highlighting a client's awareness of their unconscious defences or fears in therapy (Waska, 1999).

PDT for Sexual Assault PTSD

PDT for sexual assault PTSD would consist of bringing the client's awareness of unconscious defences and avoidance of their repressed memory of the assault into awareness. The therapeutic relationship, within which the client begins the process of awareness in coming to terms with their assault experience, is integral. Laufer (1988) posits that PTSD is a normal adaptive process to an abnormal event. PDT for sexual assault PTSD would consist of bringing this to clients' awareness, with possible greater acceptance of experiences and symptoms. In confronting the event, PDT seeks to help the client recognise what the specific circumstance of the trauma means for their life and wellbeing (Abbas and Macfie, 2013). PDT attempts to make meaning in relation to the original trauma and related behaviours, thoughts, and emotions (Lindy, 1993).

The problem of validity in psychodynamic theory is an often-cited criticism as the model's theory of human development, psychopathology, and treatment techniques

are rarely based on direct evidence, and lack empirical support in the research literature. A critical examination of the PDT approach for sexual assault PTSD is further addressed in the review of the literature, Chapter 2.

An introduction to Humanistic Psychology and therapeutic approaches to PTSD is outlined in the next section.

Humanistic Psychology

Humanistic psychology emerged as an alternative to psychoanalysis and behavioural and cognitive approaches. The focus of the human potential movement in the United States in the 1960s emphasised personal growth and self-awareness for improved relationships, and more effective interpersonal skills. One of the main proponents of the humanistic approach was Carl Rogers (1951) who developed person-centred therapy (PCT) (Rogers, 1951). Rogers (1951) criticised the deterministic, pathologising nature of psychoanalysis, and the mechanistic assumptions and practices of behaviourism. He opposed the use of diagnostic labels and traditional psychological testing that was designed to discover pathology; terms such as doctor, patient, symptoms, diagnosis, illness and treatments, were rejected as patients became clients (Elkins, 2009).

The premise of Rogers's theory is that individuals constructively strive to reach their full potential, which he termed an *actualising tendency*[7] (Kahn and Rachman, 2000). Healthy personality development is based on caregivers' unconditional positive regard (non-judgemental acceptance), and genuineness, from which develops unconditional positive self-regard (self-esteem), or congruence, that promotes the process of actualisation. Rogers argued that caregivers' place conditions on love and approval, e.g., 'I love you when you're well-behaved', that conveys non-genuine, contrived ideals based on the individual striving to sustain and maintain the approval of significant caregivers. Thus, according to Rogers, there are three conditions necessary to facilitate individuals' full potential: unconditional positive regard

[7] Actualisation is the process of mobilising one's potentialities and realising them in concrete form. According to Carl Rogers, all humans have an innate actualising tendency to grow and realise the self fully. See also self-actualisation.
https://dictionary.apa.org/actualization

(respecting the other), genuineness, or empathic understanding, and congruence (Kahn and Rachman, 2000). In PCT, the therapeutic relationship focuses only on the subjective experience of the client, where the therapist is required to replicate these three core conditions to avoid imposing an agenda or guiding the client.

Rogers' PCT posits that all information necessary in therapy for client change exists in the present, that it is impossible to ever know the past. According to Rogers (1986), theories of human development are untestable and thus render the past unnecessary. Only those values that are relevant to the individual in the present are important. The client's therapy frame, therefore, involves doing what she wants to do, using her own thoughts, feelings and frame of reference, acting without needing permission or approval from others. Rogers' empathic stance in understanding clients' subjective reality as experienced in the moment requires the therapist to orient toward this client's 'frame of reference', to fully understand the client's world (Kahn and Rachman, 2000).

PCT for Sexual Assault PTSD

PCT actively targets daily challenges that clients with PTSD confront that may be related to the trauma, to help with their symptoms (McDonagh, 2005). Modified aspects of PCT that are used for PTSD include psychoeducation to, (1) help clients understand how symptoms of PTSD are disrupting their day-to-day functioning; (2) strategies for approaching day-to-day difficulties; and (3) problem-solving skills outside of therapy sessions in the form of homework, to monitor stressors and practice new skills (Belsher et al., 2017).

PCT is a structured treatment approach that can be modified to mirror the treatment under investigation (Belsher et al., 2017). The goal of PCT is to enhance clients' ability for effective problem-solving and strategies to manage trauma stressors and improve psychosocial functioning (Belsher et al., 2017). Along with psychoeducation, clients gain insight into how PTSD symptoms influence behaviours. Adaptive solutions to PTSD stressors enhance clients' psychosocial functioning and interpersonal relations (Belsher et al., 2017). Increased positive self-regard emerges

from a caring, therapeutic relationship, including shared goal setting, congruence and empathy (Frost, Laska and Wampold, 2014). As clients practise more adaptive problem-solving approaches within a beneficial therapeutic relationship, the client begins to develop improved functioning and wellbeing (Frost, Laska and Wampold, 2014).

There is conflicting evidence for PCT effectiveness as a stand-alone treatment for PTSD. For example, although Elliott et al. (2013) found very large pre, post and controlled effects, as well as significant comparative effects for PCT therapies in trauma presentations for interpersonal and relational difficulties, including complex trauma, other criticisms point to a lack of effectiveness in treating a wider range of mental health presentations. For example, PCT can be used to treat common mental health problems, such as depression and anxiety, with many studies showing the benefits of PCT techniques in people with mild to moderate symptoms. However, research outcomes for the treatment of sexual assault PTSD make little reference to PCT, over and above those recommended trauma-focused treatment (TFT) approaches for PTSD, and it is not yet apparent in enough studies, utilising qualitative or quantitative paradigms, how PCT provides the conceptual underpinning to therapeutic work with traumatised clients (Joseph, 2004). Furthermore, it is less clear whether this approach for PTSD can lead to lasting change (Elliott et al., 2013).

Joseph (2004) suggests that PCT is not usually considered within literature and research on trauma, raising questions over the appropriateness of PCT for trauma survivors. PCT has received little research attention in relation to trauma due, in part, to PCT therapists' lack of support for Evidence-Based Therapy (EBT), (sometime referred to as Evidence-Based Practice (EBP), which are psychotherapy approaches that have shown to be effective in peer-reviewed, scientific experiments. PCT therapists also object to what they see as the inappropriate medicalisation of therapy shaped around psychiatric disorders (Bozarth, 1991). Emphasis on the phenomenological stance of PCT in qualitative research paradigms, marginalises the model further within mainstream psychology (Joseph, 2004). Although research evidence suggests that PCT provides a conceptual framework for understanding the phenomenology of PTSD, conceptual issues remain. The term PTSD implies that the phenomenology of PTSD is indicative of disorder, and as with all diagnostic

classifications implies a categorical judgement. Rogers' theory suggests that the phenomenology of distressing intrusive thoughts and attempts at avoidance are normal processes, associated with cognitive attempts to reintegrate self with experience; the PCT approach does not view trauma as evidence of malfunction. Joseph (2004) emphasised that lack of evidence for a therapy does not mean that that therapy is ineffective, only that it has not yet been subject to scientific scrutiny in relation to the Diagnostic and Statistical Manual of Mental Disorders (DSM, 2013). PCT, like PDT, is a well-established approach that has a large body of research, though not empirically supported.

A critical examination of the PCT approach for sexual assault PTSD is further addressed in the review of the literature, Chapter 2.

Other empirically supported, non-trauma approaches for PTSD treatment are outlined in the next section.

Other Non-Trauma Approaches for Sexual Assault PTSD

A review of the literature showed that the greatest number of studies available were from trauma-focused treatment approaches, and for mixed-trauma-type PTSD (the literature review is fully appraised in Chapter 2). Outcomes and efficacy that endorse and promote current research approaches are within the medical model approach (Shea, et al., 2020). Research studies examining non-TFT treatment approaches for PTSD, such as PDT, PCT and interpersonal psychotherapy (IPT), for outcomes and efficacy are sparse. Non-TFT approaches for PTSD that focus on skills training and/or cognitive restructuring, such as acceptance and commitment therapy (ACT), are evidenced and empirically supported in research studies, but they are few (Shea et al., 2020). Additionally, research for non-TFT approaches such as mindfulness, meditation, and Skills Training for Affective and Interpersonal Regulation (STAIR), is scant, even though research studies indicate promising outcomes in these treatments for PTSD (Shea et al., 2020).

The next section considers the medical models' trauma-focused treatment approaches that are recommended for the treatment of PTSD.

A Broad Historical Perspective of the Medical Model in Psychotherapy

Psychoanalysis

Sigmund Freud (1856-1939) developed a talking cure and a procedure known as psychoanalysis. In Freud's psychoanalytic theory, disturbances in adults were the result of incognisant memories of early traumatic experiences that were identified within levels of awareness or consciousness. That is, the conscious mind, which consists of everything inside of our awareness, and the unconscious mind, a repository of feelings, thoughts, urges, and memories that are outside of our conscious awareness (Freud, 1920). Thus, behaviour and personality are impacted by the unique interaction of a conflicting psychological jarring, operating at conscious and unconscious levels, that influences human behaviour. Using a number of different process methods such as defence mechanisms, for example, projection, repression, denial and regression (defence mechanisms are very valuable aspects of Freud's work), a trained psychoanalyst is able to unearth deeply buried unconscious memories, thus bringing them into consciousness in order that the patient can begin to acknowledge and come to terms with internal unconscious conflicts.

Psychoanalysis was developed from within a medical community, and modelled within medical terms (Elkins, 2007). As with the application to physical illness and healing, a *patient* described her symptoms to the *doctor* and the doctor prescribed a treatment to cure the illness. Thus, in its most condensed form, this same medical model was applied to psychological problems and became a clinical method for evaluating and treating psychological disorders, continuing to be used as the primary descriptive representation for psychological psychotherapies in mental health today (Elkins, 2007). If mental disorders have a physical cause, they can be diagnosed by listing the symptoms and adjusting the physical cause. This approach to mental health

is further examined in the next section, in a brief outline of the rise of behaviourism and its impact on the approaches to the field of psychology and in mental health practice.

From Consciousness to Behaviour

Behaviourism, also known as behavioural psychology, was developed by the American psychologist, John Watson (1878-1958). The basic tenet of behaviourism is a focus on symptoms, whilst ignoring any underlying issues of disturbed behaviour. Watson believed that psychology should primarily be based on scientific observable behaviour. Behaviourists aimed to transform psychology into a more objective scientific discipline, much like biology or chemistry, that focused on measurable, observable phenomena, rather than Freud's unobservable internal levels of conscious and unconscious processes that influence human behaviour. They argued that thoughts and emotions, or internal cognitions, could not be measured or documented, and so they were not relevant for the study of human behaviour. Many modern therapies, such as exposure therapy used to treat PTSD for example, continue to rely in part on behaviourist techniques. Cognitive behavioural therapy (CBT) and certain desensitisation treatments, such as those used to treat anxiety, are direct therapeutic descendants of behaviourism (Elkins, 2007).

However, behaviourism was largely overshadowed because of the cognitive revolution in therapy (Friesen, 2005). This shift was due to behaviourism being criticised for not examining mental processes, which led to the development of the cognitive therapy movement. The cognitive revolution in psychology further established the medical model in psychology in the United States in the 1950s and 1960s, that continues to dominate the field of psychological therapies in western culture. Several distinct eras, originations, or waves of the development of the cognitive in therapy, meant that by the 1970s, behaviour therapy had evolved into an era and a union now known as cognitive behavioural therapy, or CBT. New methods and concepts that focused on the role of maladaptive thinking patterns in emotion and behaviour, and with the intervention of methods to detect and change those patterns, began to emerge (Hayes and Hofmann, 2017).

PTSD Diagnostic Criteria: From Freud to the DSM-5

A complete discussion of Freud's contribution to the disorder known now as PTSD is beyond the scope of this study, however his work is of major significance to our understanding of how the diagnostic criteria for PTSD in the DSM evolved in the United States. Freud drove contemporary understanding of PTSD. In Freud's (1856-1936) early work on 'anxiety neurosis' he found that a significant psychological event could lead to physical manifestations (e.g., hallucinations, loss of appetite, nervous coughing, disturbed vision, and sleeplessness). Freud proposed that the memory of the event (or trauma) could not be confronted by the individual due to intolerable mental anguish, and so the event was repressed (the restraint, prevention, or inhibition of a feeling, etc., by an individual) and 'converted' into these physical symptoms (Turnbull, 1998).

In the early part of the 20th century, Freud, along with the medical community, turned their attention to 'shell shock' in the aftermath of the First World War (1914-1918). In the wake of war, veterans returned wounded but with no obvious physical injuries. Instead, their symptoms presented as amnesia, or a kind of paralysis or inability to communicate, but without any clear physical causes, which came to be understood as physical symptoms of psychic trauma (Turnbull, 1998). The result of noticing that exposure to traumatic incidents led to an after-effect was based on the theory that the impact of physical forces on the central nervous system (CNS)[8] produced a temporary disconnect or dysfunction, leading to the development of symptoms. This belief was strongly held and represented in the concept of shell shock, which prevailed during the First World War (Turnbull, 1998).

One can clearly see a trajectory of discourse moving towards a medical model of the theory of trauma, in seeking to understand different types of traumatic neurosis, especially those created by warfare. In Freud's 'anxiety neurosis', a primary

[8] Central nervous system (CNS) refers to the entire complex of neurons, axons, and supporting tissue that constitute the brain and spinal cord. The CNS is primarily involved in mental activities and in coordinating and integrating incoming sensory messages and outgoing motor messages. https://dictionary.apa.org/central-nervous-system

psychological event led to a physical manifestation. Early attempts to build a psychological theory of behaviour in which 'instinctual forces', or biology, gave rise to mind-body dilemmas developed. The physical *and* biochemical were found to cause mental events in various states of consciousness for trauma (Wilson, 1994). Developments in physiology and behavioural psychology led to an increasing acceptance of the existence of multiple dimensions in traumatic stress reaction. The result has been the current concept, that the impact of a traumatic stressor will have clearly defined psychological, and inter-relational biological consequences, which are unique to PTSD (Turnbull, 1998). This development has rather practical implications for diagnosis and treatment as the concept that mental and emotional problems are analogous to biological causes, implies they are amenable to cure or improvement by specific treatment (Deacon, 2013). A biological approach complements the medical model within psychological diagnostic techniques well, and with regards to the latest medication treatment, almost every type of psychotropic medication has reported efficacy in managing the symptoms of PTSD, from anxiety and depression to psychological distress and insomnia (Friedman, 1991).

From Freud to the present day, the history of the medical model's development of classification and diagnosis for PTSD is contentious. With each revision of the DSM, the criteria for PTSD have changed significantly (North et al., 2016). In 1994, following publication of the fourth edition of the DSM (DSM-IV), criteria for PTSD were criticised for presenting innumerable ways to address the diagnosis (North et al., 2009). Three new symptoms were added to the DSM-5 criteria for PTSD that were criticised as being both nonspecific symptoms for PTSD, and for over-pathologising the criteria for diagnosis. Further criticisms around which and how many symptoms to include in the criteria for PTSD, how they should be grouped, and even whether PTSD is a valid diagnosis at all, were contested (Brewin et al., 2009). Research has demonstrated substantial overlap of PTSD symptoms with depressive and anxiety disorders, attracting criticism of the validity of PTSD as a distinct disorder, by not linking symptoms to the traumatic event as defined in the diagnostic criteria for PTSD (Rosen, Spitzer and McHugh, 2008). Ongoing, unresolved issues in the diagnostic criteria for PTSD and how the criteria shape current conceptualisations of PTSD, need further examination (Pai, Suris and North, 2017).

Psychotherapy research using medical methodology has reached a dichotomy of having developed effective psychotherapies for the treatment of PTSD, but with little empirical evidence from the dominant RCT paradigm to directly inform treatments (Deacon, 2013). This is due, in part, to the nature of generalisability and reductionism in research methodologies for the medical model. Reductionism refers to an approach to explain attempts to reduce complex structure or behaviour into less complex units, such as used in classification and diagnostic manuals. This, coupled with empirically supported treatment research methods for sampling in RCTs, and of generalising outcomes, has serious implications for treatment approaches in researching PTSD, as well as for this study.

The next section comprises two definitions of PTSD; the first from the ICD-11 and the second from the DSM-5, and includes recommendations for the treatment of PTSD, as outlined by the National Institute for Health and Care Excellence (NICE, 2018).

Definitions

The International Classification of Diseases and Related Health Problems (ICD-10 Version: 2019) defines post-traumatic stress disorder (PTSD) as:

> a delayed or protracted response to a stressful event or situation (of either brief or long duration) of an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone (ICD-10 Version: 2019)

Presenting symptoms associated with post-traumatic stress disorder (PTSD), according to ICD-10 are outlined:

> Typical features include episodes of repeated reliving of the trauma in intrusive memories ("flashbacks"), dreams or nightmares, occurring against the persisting background of a sense of "numbness" and emotional blunting, detachment from other people, unresponsiveness to surroundings, anhedonia, and avoidance of activities and situations reminiscent of the trauma. There is usually a state of

> autonomic hyperarousal with hypervigilance, an enhanced startle reaction, and insomnia. Anxiety and depression are commonly associated with the above symptoms and signs, and suicidal ideation is not infrequent. The onset follows the trauma with a latency period that may range from a few weeks to months (ICD-10 V:2019. F43.1. Post-traumatic stress disorder) (see Appendix 4 for full definition outline).

The *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5, 2013), cited sexual violence as also meeting the criteria for PTSD:

> ... the diagnostic criteria for DSM-5 draw a clearer line when detailing what constitutes a traumatic event. Sexual assault is specifically included... [and] symptoms that accompany PTSD... and proposes four distinct diagnostic clusters instead of three. They are described as re-experiencing, avoidance, negative cognitions and mood, and arousal (DSM-5, 2013).

A definition and brief description of PTSD symptoms re-experiencing; avoidance and hyperarousal are:

> The symptoms are characterized by (a) reexperiencing the trauma in painful recollections, flashbacks, or recurrent dreams or nightmares; (b) avoidance of activities or places that recall the traumatic event, as well as diminished responsiveness (emotional anesthesia or numbing), with disinterest in significant activities and with feelings of detachment and estrangement from others; and (c) chronic physiological arousal, leading to such symptoms as an exaggerated startle response, disturbed sleep, difficulty in concentrating or remembering, and guilt … (American Psychological Association (APA), 2014).

The National Institute for Health and Care Excellence (NICE, 2018) guideline outlines current therapeutic interventions that have been developed specifically to treat PTSD for adults (see Appendix 5 for full description of treatment recommendations for PTSD). These interventions include:

> Offer an individual trauma-focused CBT [Cognitive Behavioural Therapy] intervention to adults who have acute stress disorder or clinically important symptoms of PTSD and have been exposed to one or more traumatic events within the last month. These interventions include:
> Prolonged Exposure (PE),
> Cognitive Therapy or Cognitive Processing Therapy (CPT),
> Eye Movement Desensitisation and Reprocessing Therapy (EMDR), and
> Narrative Exposure Therapy (NET)
>
> (NICE, 2018)

A broad definition of CBT theory and practice, is based on several core principles, including:

> Psychological problems are based, in part, on faulty or unhelpful ways of thinking; psychological problems are based, in part, on learned patterns of unhelpful behaviour; people suffering from psychological problems can learn better ways of coping with them, thereby relieving their symptoms and becoming more effective in their lives (American Psychological Association (APA), 2017).

NICE (2018) recommendations for PTSD include only evidence based TFT approaches, standing firmly on the lofty shoulders of 'scientific' research evidence. Some of the controversies surrounding TFTs for PTSD is critically evaluated later in this chapter and further appraised in Chapter 2, including the core assumptions involved with PTSD classification and diagnosis; the validity of a PTSD diagnosis in considering various types of traumas, for example, combat trauma and trauma from sexual assault; and the persistent and enduring difficulty of arriving at a consensus for what qualifies as a PTSD diagnosis (Weathers and Keane, 2007). Moreover, in view of the WS offering *only* non-TFT approaches for sexual assault PTSD, such as PDT and PCT, it could be argued whilst NICE (2018) critically reviews those studies which meet their criteria; some treatment models are unable to secure contemporary research funding because they are unable to demonstrate efficacy of treatment. NICE (2018) favours large quantitative studies neglecting the lived experiences of those

suffering with PTSD. As such, NICE (2018) tells only half of the story within contemporary research literature for the development of optimum psychological therapies to treat PTSD.

Terr 's (1991) classification of trauma types is proposed as a framework to guide therapists' to assess levels of risk at the WS (Terr's classification model is discussed in detail in Chapter 3). Non-TFT phase orientated approaches, such as The Stages Trauma Model developed by Judith Herman (1992), is a psychosocial model of therapy that focuses on the encounter between an individual and her environment. Psychosocial models incorporate different psychotherapy approaches and very often includes support, education and guidance to individuals and their families. The guiding principles of the stages model of recovery is to re-establish clients' psychological facilities damaged by the traumatic event. Phase model approaches provide a context for therapy intervention at the WS in which the central position of the therapeutic relationship forms the basis for the beginning of recovery for clients.

TFT and non-TFT approaches are reviewed in Chapter 2, which includes a critical evaluation of some of the controversies surrounding the validity and reliability of the DSM classification system in medical model treatment approaches for PTSD.

Medical Model TFT Approaches for Sexual Assault PTSD

Typically, the focus of TFT approaches for PTSD is not necessarily on the traumatic experience itself but on the maladaptive behaviours that develop post the traumatic event (Foa, Keane and Friedman, 2000). For example, treatment for the development of PTSD symptoms re-experiencing and arousal would be identified as conditioned[9] responses of the traumatic even; CBT intervention is aimed at reducing those responses.

[9] Conditioned response (CR): in classical conditioning, discovered in the early 20th century by Ivan Pavlov, is the learned or acquired response to a conditioned stimulus. Also called conditioned reflex.
https://dictionary.apa.org/conditioned-response

A critical examination of the medical model approach for sexual assault PTSD is addressed in the literature review, Chapter 2.

The next section reflects on cross-cultural implications for the three psychotherapeutic approaches previously examined, in considering both universal values and ethical theory in treatment approaches for PTSD.

Cross-Cultural Relevancy of TFT and Non-TFT Approaches for PTSD

The APA and DSM-5 uphold Western European values, in which treatments are influenced by a standard set of beliefs that are cross cultural and universal. It is an assumption that denies the uniqueness of ethnic history, practices, aspirations, and experiences in the process of treatment and change, which can impact treatment disengagement, treatment failure, or culture-related stereotypes (Wilk, 2016). Treatment approaches that primarily focus on symptom reduction or the development of new skills, do not attend to the importance of ethnic values and their influence on therapeutic relationships and processes (Plumb et al., 2009; Asnaani and Hofmann, 2012). Durie (2003) argued that traditional, mainstream psychological approaches such as CBT, are less likely to address the synergistic relationship between the individual, the communal, and the environment, as they do not acknowledge the pervasive nature of historical and intergenerational trauma caused by acts of atrocity or global wartime violence that have systematically exacerbated a range of psychological and social conditions. For example, after the 2004 tsunami in Sri Lanka, hundreds of trained therapists from around the world travelled to help survivors with their psychological recovery, assuming that, given the history of civil war in Sri Lanka, the development of PTSD would increase (Muller, 2013). However, this was not the case. Western-trained therapists used the DSM-5 diagnostic criteria for survivors without considering the effect of culture and coping mechanisms resulting from exposure to a traumatic event (Muller, 2013).

Culture is defined as a shared system of values, beliefs, and learned patterns of behaviours; and not only defined by ethnicity (Low, 1984). Culture is also shaped by

factors such as proximity, education, gender, age, and sexual preference. Despite limited funding and political conflicts identified as barriers to relief efforts, Sri Lanka was fortunate in drawing upon a well-developed community health infrastructure, as well as local and international resources. Non-Governmental Organisations (NGO)[10] provided spiritual guidance and promoted Buddhist principles of meditation to promote recovery (Yamada et al., 2006). In the community, Sri Lankan citizens began to provide food, clothing, and shelter, initiating informal networks of family, friends, and work colleagues to travel to areas most affected, offering direct assistance in searching for survivors, transporting victims to hospitals, and delivering medical supplies, etc. Many individuals in the surrounding villages supported these operations by collecting donations and organising the delivery of relief goods (Yamada et al., 2006).

For citizens of Sri Lanka, it seemed that the priority was aiding those around them, rather than seeking individual treatment themselves. In western cultures, we see individual psychological problems as *causing* social difficulties; in Sri Lanka and other Asian cultures, it is the opposite, as social bonding is created by acts of helping others that aid in minimising the development of psychological problems (Muller, 2013). Psychological literature research has a tendency to frame ethnic and cultural values-based interventions within dominant Western European values without acknowledging the importance of indigenous cultural values and practices (McLachlan, Wirihana and Huriwai, 2017).

Derald Wing Sue (Sue, Arredondo and McDavis, 1992) provided a conceptual framework for cross-cultural therapeutic competencies to enable practitioners to become more aware and sensitive to their own cultural heritage, as well as to value and respect those of others. In providing therapeutic interventions to an increasingly diverse client base, attention must be given to the applicability of the dominant

[10] An NGO is a non-governmental organisation, typically defined as a voluntary group or institution with a social mission, which operates independently from the government. NGOs or similar organisations exist in all parts of the world. An NGO may also be called non-profit, charity, Non-Profit Organisation (NPO), Civil Society organisation (CSO), Citizen Sector Organisation (CSO), Social Benefit Organisation (SBO), an advocacy organisation, voluntary organisation, Grassroots Support Organisation (GSO), and Non-State Actor (NSA). Independent sector, volunteer sector, and civil society are also terms used for NGOs. https://www.ngosource.org/what-is-an-ngo

theoretical orientations (MacDougall, 2002). When considering multicultural therapeutic competencies, PCT is most vulnerable to criticism in not modifying responses to cultural considerations (MacDougall, 2002). As the therapist profession becomes more diversified, and further efforts are made to focus on the needs of an increasingly diversified client base, possible modifications of Rogers' approach could be considered, although limited data investigating outcomes for grounding potential components of PCT within broader universal values and ethical theory are now emerging.

Factors of ethnic minority group membership have also been associated with greater disengagement (Fortuna, Alegria and Gao, 2010). Though some studies have found both ethnicity and socioeconomic status (SES) to be related to disengagement (e.g., Arnow et al., 2007), other studies have not (e.g., Lambert, 2013). Anderson, Bautista and Hope's (2019) study of the therapeutic relationship and factors which contribute to disengagement, indicated the greater perceived multicultural competence of the therapist was associated with increased likelihood of therapy completion, and perceived multicultural competence of therapists was also positively related to treatment satisfaction and therapeutic relationship strength (Anderson, Bautista and Hope, 2019). Merging the culturally specific in psychotherapy is advancing towards establishing multicultural competencies within both theory and practice for mental health disorders such as PTSD (Tummala-Nara, 2015).

The relationship between mental health disorders and sociocultural factors has different implications for research and treatment, and in our understanding of the relationship between mental health disorders and culture (Thakker, 1999). If, as claimed by the DSM and the medical model approach, that symptoms of mental illness are caused by a physical disease within the organism's system, it should be assumed that mental disorders would manifest similarly within diverse cultural groups across all human populations. However, research suggests that there are important differences in mental health disorders, in both variability and how they are expressed world-wide (Draguns, 1995; Kleinman and Cohen, 1997). Psychological and sociocultural inconsistences challenge the medical model view and does not explain the way in which mental health symptoms manifest across various social groups.

Constructivist principles may provide a fitting foundation for the development of a more sociocultural-specific conceptualisation, in critically evaluating the diagnosis of PTSD. Constructivism is a theory that holds that humans are meaning-makers in their lives, and essentially construct their own realities. It is an approach embedded in constructivist and relativist philosophy; people actively construct or make their own knowledge and reality, determined by one's learned experiences formed within relationships (Granvold, 1996). In various psychotherapeutic approaches under constructivism, the client is viewed as an active participant in their own wellbeing. For example, the collaborative therapeutic relationship in non-medical psychotherapeutic approaches, such as PDT, is an agreement for balancing responsibilities for client change between therapist and client (Thakker, 1999). Emphasis on the interpersonal and relational context of human experience and behaviour; a constructivist definition can more capture the multidimensional and dynamic nature of human psychopathology. Hence, though there is considerable similarity across human beings in the nature biological structures, there may also be present a complex interaction between the various aspects of the system across psychology, biology, and culture: an underlying, symbiotic relationship (Thakker, 1999). (The epistemological stance of constructivism is embedded within the philosophical paradigms of this study, which is fully reviewed in Chapter 3, Methodology).

The Current Study

The previous section introduced disengagement from therapy treatments models, exploring the history of non-medical psychotherapeutic approaches and medical model approaches for psychotherapeutic treatments for PTSD. This research study focused on clients presenting in therapy treatment with symptoms of PTSD from sexual assault, and their subsequent disengagement from therapy treatment. The following section contextualises sexual assault in terms of understanding the implications and impact on the individual and their quality of life.

Sexual assault PTSD in context and treatment recommendations are summarised in the next section.

Sexual Assault PTSD in Context

Sexual Assault

Sexual assault has been shown to be the greatest risk factor associated with the development of PTSD in women (Klump, 2006). Sexual assault can negatively impact women both physically and emotionally and many women will go on to develop PTSD symptoms, post assault (Campbell, Dworkin and Cabral, 2009). Following sexual assault, victims can experience shock, intense fear, numbness, confusion, feelings of helplessness and/or disbelief, in addition to self-blame, hyperarousal and high levels of anxiety (Vickerman and Margolin, 2009).

Prevalence of PTSD in sexual assault survivors is markedly greater than the national prevalence of the disorder generally, as evidence suggests that trauma associated with sexual assault may be different from other forms of trauma, possibly due in part, to the increased incidence of depression and risk of suicide concurrent in interpersonal trauma (Kimerling, Clum and Wolfe, 2000; Chivers-Wilson, 2006). For instance, PTSD has been reported to affect between 9% and 15% of the general population and almost 50% of individuals who have been assaulted (Feeny et al., 2004). Breslau et al. (1991) study assessed the differential risks of PTSD across types of trauma exposure and reported that incidence of PTSD was highest after rape (49%), followed by other forms of sexual assault (23%), compared to the incidence of PTSD after being shot or stabbed (15%); a serious car accident (2.3%); other kinds of serious accidents (16.8%), and following natural disaster (3.8%).

Research examining disengagement for different trauma types, and effects on outcome has begun to emerge in the field. Early indications from research examining post traumatic symptoms indicates negative outcomes can differ as a function of the type of trauma experienced. For example, research examining PTSD symptom improvement in different groups of trauma survivors has found that PTSD symptoms are more prevalent in sexual assault survivors than other types of traumas. Shakespeare-Finch and Armstrong, (2010) research demonstrated that negative

outcomes can differ relevant to type of trauma experienced. In a comparative study of three groups comprising sexual abuse, motor vehicle accidents, and bereavement; results indicated differences in improvement between the groups, with the bereaved group reporting higher levels of improvement than other survivors, and sexual abuse survivors demonstrating higher levels of PTSD symptoms than the other two groups. Differentiating trauma type in research and may enable therapists to meet the needs of the client that are more appropriate to client's trauma type needs, that may contribute to reducing disengagement.

Psychological health is compromised following interpersonal trauma and many psychological therapeutic interventions are available, but with varying efficacy (Chivers-Wilson, 2020). The effectiveness of interventions that specifically target reducing distress in adult victims of sexual violence are crucial. Factors such as onset, severity and progress of PTSD following sexual assault need to be considered. The 'one-size-fits all' iterations of TFT approaches to treat symptoms and improve outcomes for PTSD do not engage with the interpersonal trauma commonly experienced by women post-sexual assault. It is imperative that effective and efficient treatment options for sexual assault PTSD are identified (Regehr et al., 2013)

Psychotherapeutic approaches for the treatment of PTSD, as outlined in this introduction, are reviewed further in Chapter 2.

The next section examines sexual assault PTSD in context regarding available treatment approaches, including TFT and non-TFT, as well as current research literature.

PTSD in Context

Sexual assault is one of many trauma types that results in individuals developing symptoms of PTSD, and for which trauma-focused therapies are administered. PTSD symptoms can result from a traumatic event or series of events, experienced by individuals as physically or emotionally harmful or threatening, that can have lasting and adverse effects on individual functioning and physical, social, and emotional well-being. Natural disasters, sexual abuse, domestic violence, serious injury, illness,

neglect, deprivation, traumatic grief, victims of crime, accidents, school/work bullying, bereavement and loss, are some examples (Sullivan, 2009).

There are three main types of trauma presentation: acute, chronic, and complex. Acute is a single traumatic incident; chronic refers to trauma that is repeated and prolonged over time, for example domestic violence; and complex trauma results from exposure to multiple traumatic events that are persistent and interpersonal in nature, such as child sexual abuse (Sullivan, 2009).

There are arguments to suggest that for sexual assault PTSD sufferers in particular, the type of treatment offered has an important role in whether individuals will remain engaged (Herman, 1992; Walker, 2017). Clients with PTSD differ significantly from one another with respect to trauma, vulnerabilities, developmental stage when traumatised, comorbid conditions, and assorted social factors that affect course and treatment responses. Similarly, psychosocial (non-TFT) and biological (TFT) therapies vary greatly. In determining suitable treatment approaches, consideration of the individuals' treatment needs should be addressed.

A review of the research literature emphasised that engagement rates for recommended TFT approaches to treat PTSD continue to be hampered by non-treatment responses, as well as disengagement, despite being specialist therapies (Larsen, Fleming and Resick, 2019), with no one model showing more effectiveness or superiority over another (Cusack et al., 2016). Current research shows TFT approaches reduce symptoms of PTSD for clients, however, high rates of disengagement continue to be evident from these treatments (Schottenbauer et al., 2008), with some therapists believing that TFT approaches can exacerbate client disengagement (Imel et al., 2013).

Significantly, recommended TFT approaches for PTSD have not shown improved engagement over other non-TFT approaches (Imel et al., 2013). Indeed, several non-TFT psychotherapies for PTSD have demonstrated clinical effectiveness, including non-inferiority or equivalence with TFT approaches in some comparison trials, including PDT and PCT (Yager, 2018). If research to predict client engagement rates remains centred on client measures that show little or no improved level of

engagement with these treatments, then evidently, current measures to reduce disengagement from recommended TFT approaches for PTSD need to be revisited.

Lack of research studies on non-TFT approaches to treat PTSD and the neglected focus in empirical treatment literature of healing, recovery, and post-traumatic growth, with the focus instead on reducing symptoms and avoiding negative outcomes, have produced a worrying trend in the research field. Possible causes for the continued development and utilisation of TFT approaches to treat PTSD are explored further in Chapter 2, including the unhealthy interest in pharmaceutical companies' involvement in revising the DSM, and ethical considerations of the continued medicalisation of treatments for PTSD.

TFT approaches for PTSD tend to focus on measurable symptoms of PTSD, whereas non-TFT approaches focus on growth and wellbeing, which are non-measurable. Hence, without so-called 'measurable evidence', studies to determine the efficacy of non-TFT approaches for PTSD are scarce. Though equal outcome effectiveness for reducing PTSD symptoms is evident from both TFT and non-TFT approaches (Yager, 2018), the wellbeing of individuals does not produce a profit to private companies and pharmaceutical corporations. Deacon (2013) states the medical model approach to science, policy, and practice has dominated the United States healthcare system and western culture for more than three decades. The DSM is developed by an APA-appointed management panel consisting of experts in various fields of psychiatry and mental health, many of whom serve as scientific advisors for drug companies or conduct industry-funded research. This bias, though possibly unintentional, still has the appearance of bias, impacting both research integrity and public trust. As Migone (2017) states, mental illnesses can be profitable because they increase the use of medications. Simply stated, most non-TFT are non-medication approaches that do not produce revenue. A critical examination of the controversies surrounding the predominance of the medical model approach in the literature for the treatment of PTSD is further appraised in Chapter 2.

A therapy service that can reduce distress and improve quality of life for clients with symptoms of PTSD is important for two reasons: firstly, in helping clients to make

long-term meaningful change in their lives (Beck et al., 2016), and secondly, improving treatment outcomes can serve as a function of improved client engagement (Tompkins, Swift and Callahan, 2013). The WS gave me this opportunity to examine this trend in client disengagement, in an attempt to shed light on understanding why clients disengage from PTSD therapy before completing their treatment.

The next section outlines my position within the research field of client engagement for clients presenting with sexual assault PTSD symptoms and examines how my clinical and training experience have shaped and directed this research thesis.

Author's Positionality and Conceptual Framework

The idea for this research study was driven by questions I held about clients who disengaged from therapy, and without a follow-up system that meant there was no procedure to establish cause of disengagement. These questions arose during my work as a psychodynamic psychotherapist in a London-based mental health charity service.

I have worked in the third-sector charity mental health service as a psychotherapist for over 10 years. My clinical training included an honorary post in the specialist psychotherapy Women's Service (WS) in a London NHS hospital, which involved interviewing, assessing, and conducting individual psychotherapy with women who had experienced gender-based violence and childhood sexual abuse.

My clinical practice includes support for women and children affected by domestic and sexual violence. The WS works with women who have experienced any form of sexual violence, including child sexual abuse, rape, sexual assault, sexual exploitation, prostitution, trafficking, honour-based abuse (including rape, abuse, and enslavement), and female genital mutilation (FGM). The WS offers between six and 46 weeks of therapy to women. The number of therapy sessions is determined at assessment by complexity of presentation, criteria for risk and PTSD symptoms recognised.

During my training and clinical work experiences, I observed that clients presenting with sexual assault PTSD symptoms have difficulty in engaging with and trusting the therapy process, which can reflect their general approach to other relationships and life experiences. I have also learned that research for client disengagement is primarily focused on retrospective data from client variables. In Chapter 2, it will be shown that very few accounts are available in the literature of clients' therapy experiences post-early disengagement, yet ample research data are available for those clients that have successfully completed therapy, which obscures and distorts research outcomes for effective treatment approaches for sexual assault PTSD.

This research thesis has been filtered through factors related to my worldview and point of reference about my world. My own position in relation to this research establishes and reflects my beliefs about my world: the world that I inhabit (Kivunja, 2017). Indeed, my worldview has shaped the beliefs and principles of this thesis, which in turn, is interpreted throughout all stages of the research. Thus, an examination of my own professional journey is the lens through which this research was filtered. My professional journey and training as a psychodynamic psychotherapist informed entirely this research thesis process. I am not a scientifically trained therapist. I do not work within the medical field or utilise medical model treatments. None of my personal or professional history, or experience of therapy, is informed from a medical model perspective. I am a non-traditional, second-career student. These perspectives inform and colour the lens through which this thesis was developed, and all of the decisions that were made in terms of approach and methodology choices. Qualitative research involves asking individuals about their experiences of things that have happened in their lives. It enables me, as a novice qualitative researcher, to obtain insight and understanding of the world as another experiences it.

Research in the area of disengagement from sexual assault PTSD has provided me an opportunity to explore, question and build upon knowledge and ideas yet to be formulated within this field of research. A highly detailed understanding of the emotional processes that occur as the result of disengaging from an unsatisfying and unhelpful therapy allows for enhanced understanding and further consideration to be

made when choosing an appropriate therapeutic intervention, to assist those who are similarly affected by such an experience.

The experiences of my life, academic and professional training, and worldview have shaped all aspects of the direction of this thesis; including the philosophical foundations[11] that were considered, and which are outlined in depth in this study.

Class, Gender, and Race

It is important for this research to make a note about issues relating to society, gender, and race. There will be times during the study that issues around gender will be mentioned as they have been central to the different directions that research in therapeutic interventions for PTSD have taken to date. This study chose not to focus on the influence of society, and more than one gender or race, and how they relate to mental health therapy experiences. While these are important issues to consider, current knowledge regarding early disengagement from therapy is very comprehensive and contains a multi-faceted approach. Hence, it was felt necessary to make the primary focus of this study the most commonly reported forms of early disengagement from therapy for PTSD for sexual assault, and the availability of current research in that alone.

Purpose of the Study

The purpose of this research study was to contribute to the development of awareness amongst therapists involved in the therapeutic treatment of clients presenting with PTSD following sexual assault. In so doing, it hopes to inform the direction of the mental health service treatment of clients with PTSD in the future.

Women presenting in therapy with PTSD symptoms due to sexual assault and who disengage from therapy appear to be contextualised in research literature within the paradigm of ‘it must be the client’. To begin to shed some light on possible explanations, this research study asked the client directly and in their own voice, why

[11] Creswell and Creswell (2018)

a decision to leave therapy early was made. This research called attention to what influences a client's decision to disengage from therapy. It also explored the profile of the client regarding predictors and characteristics of clients with PTSD as a means to inform disengagement, as well as the availability of research data for what is purported to be effective therapy models for the treatment of PTSD.

In attempting to discover what influences clients to disengage from therapy early, this research examined the client's experience of therapy to establish what made sense to the client about their therapy experience that was sufficient to keep them engaged to the end of their therapy agreement. The aim of this discovery was to further assist in drawing attention to some of the ways in which therapy engagement can best be addressed, and the opportunity to develop improvements to client engagement levels for the WS.

The Research Question

The research question for this thesis was drawn from my own experience, both as a clinician and as a researcher. It was generated from my beliefs, assumptions, and values: the foundations of which were informed by trauma-led mental health clinical theory and practice.

Having established the research context and the importance of the main strands of enquiry that have called attention to the knowledge gap in this area, the next section outlines the structure of the thesis.

Structure of the Thesis

This research thesis comprises six Chapters, which are organised into sections following the introductory Chapter.

Chapter 2: A Review of the Literature

This Chapter outlines how the literature search was conducted and synthesised to develop a summary of the themes that emerged from the literature review for the research question. The literature search was conducted, and reports chosen using the peer-reviewed Critical Appraisal Skills Programme (CASP) UK (2018) checklist for screening, ensuring the selected literature was assessed for trustworthiness, rigour and relevant to the research question. Additionally, grey literature was obtained from sources such as OpenGrey, to obtain current information for policies and procedures in mental health practice.

Chapter 2 provides a summary of the current writings in the field of early disengagement from therapy for PTSD. Themes from several authors are discussed in a comprehensive approach, mentioning all the major theorists or writers in the field of early therapy disengagement. Key themes from the literature are explained and interpreted, drawing on conclusions and opinions that suggest emergent trends in the field.

The Chapter concludes by demonstrating how the research question relates to the methodological framework. A presentation of the choices of methodology are discussed, establishing the research decisions that were informed and embedded in sound scholarly reasoning.

Chapter 3: Methodology, Methods, and Analysis

Chapter 3 provides a detailed account of, and justification for the methodology and analysis used. This chapter establishes a clear relationship between the research question and the existing research in the field of early disengagement from PTSD therapy, as outlined in the literature review. The process for gathering and analysing the data is clearly explained in discussing the reasons why a qualitative methodology using Interpretive Phenomenological Analysis (IPA) was chosen and tailored to achieving the best results and conclusions to answer the research question. The aim of IPA is to explore in detail how participants make sense of their personal and social world, and the meaning they bring to particular experiences and events. The process of analysing the data is described and justified.

This chapter also outlines the key elements of the methodology around the four participants selected and accessed, including an explanation for conducting recorded interviews with participants and utilising a semi-structured interview as the most suitable method for the collection of data. Ethical considerations for conducting the research and the complexity of working with human subjects are assessed. Inviting participants to experience again episodes of grief and trauma is explored, relative to the methodological framework chosen to answer the research question.

Finally, Chapter 3 discusses the limitations of the methodology, lessons learnt and what could have been modified.

Chapter 4: Findings

Chapter 4 presents and describes the data from the analysis of a qualitative methodology. Only the raw results of the analysis are included in this chapter, which describes what was done with the data found. This chapter includes a justification of the methodology used and how it was appropriate for both the type of data collected and the aims of the research, and how the data was arrived at. The overarching aim of this chapter is to present and identify significant patterns and trends in the data and display these findings meaningfully. Utilising a qualitative approach and analysing the data with IPA, the essential points that emerge after the analysis of the data will be clearly stated, supported, and argued in the discussion, Chapter 5.

Chapter 5: Discussion

Chapter 5 presents the major findings and conclusions supported by the data from the IPA analysis. The findings are interpreted in considering the implications for early disengagement from therapy for sexual assault PTSD. This chapter comprises how these findings relate to other research in the field of early disengagement from therapy and includes a comparison of similarities and variations in the findings.

The data are compared with that published by other academics in the field of early disengagement, and consideration is given to points of agreement and difference. The

discussion outlines whether the results found are consistent with expectations of those found in the literature review, and controversial differences or opposing positions are discussed with reasons, as well as implications. Key themes identified are linked back to the findings in the Literature Review and to the questions asked in thesis, presenting gaps or finding anomalies or similarities in linking the findings.

The limitations of the study are clearly delineated in this chapter and draw attention to those characteristics of design and methodology that impacted or influenced the interpretation of the findings, including any constraints to my chosen design, methods used to establish internal and external validity, and any results of unanticipated challenges that emerged during the study. Surprising, unexpected, or inconclusive results are clarified in this chapter, which concludes with suggestions for further research in the field of early disengagement in therapy for PTSD.

Chapter 6: Conclusion

This chapter synthesises the entirety of the research study. It is presented in six sections: the first section is an overview and a return to the original research question, including a summary of the key research findings; the second section draws on the implications for practice and recommendations, including the impact for the WS service, its clinicians and clients. The third section outlines the contribution to knowledge, with reference to clients' accounts of early disengagement from therapy treatment for PTSD in research. Section four is a proposal of ideas for future research projects, the foundations of which are drawn from the key findings of this research. The limitations of the study are outlined in section five, drawing attention to the design and methodology and the interpretation of the findings. Finally, the sixth section concludes with final words and reflections from the author.

Conclusion

This chapter has presented an introduction to the study, establishing definitions of PTSD therapy, sexual assault, and early disengagement in three psychotherapeutic models. The complexity and difficulty surrounding client disengagement from mental

health services generally, and from sexual assault PTSD interventions were introduced. This outline included the development of recommended TFT approaches for PTSD within a medical model framework that continues to be burdened by disengagement, recognising that its clinical outcomes are equal to non-TFT treatments for PTSD, which is perplexing. Professional and scholarly literature is replete with interventions aimed at reducing the traumatic repercussions of PTSD from sexual assault, the majority of which focus on case reflections, descriptive analyses, and uncontrolled studies. which did not meet the inclusion criteria for this thesis. Consideration of the lack of research literature concerning non-TFT therapeutic models for sexual assault PTSD and disengagement, is woven into the dilemmas and discourse of disengagement from PTSD therapy. Chapter 2 presents a critical discussion of current research on client disengagement from sexual assault PTSD therapy.

Chapter Two

Literature Review

Chapter Overview

This chapter will introduce current theory and criticism for disengagement from therapy for PTSD in sexual assault survivors. This chapter is divided into six sections. The methodology conducted for the literature review will be outlined and the results of the identified literature search will be presented. A summary of the key themes that emerged from the literature review around therapy disengagement, therapeutic approaches for PTSD, availability of research literature concerning TFT and non-TFT approaches to treat PTSD from sexual assault, the therapeutic relationship, and client-therapist effects in therapy, will be critically examined and discussed in relation to disengagement from PTSD therapy for sexual assault. A summary of the findings, and limitations of the method is also discussed in the conclusion for the chapter. This review used the Preferred Reporting Items for Systematic Reviews and Meta-analyses (PRISMA) guidelines to structure and shape the methodology for a systematic review of the current literature available (PRISMA, 2020).

This review sought to identify and discover contemporary, relevant research studies on what influences women in sexual assault PTSD therapy to disengage. To gain insight into early disengagement for PTSD sufferers, it will include an examination of the nature of sexual assault PTSD through the lens of three therapeutic approaches: the medical model, psychodynamic therapy and person-centred therapy, in order to help clarify those influences that necessitate a client's decision to end therapy. Potential gaps in the literature will be highlighted, such as qualitative research from the client's perspective, as quantitative studies determining the effectiveness of treatment tend to dominate the field. A more holistic framework approach, characterised by the treatment of the whole person is discussed, considering mental

and social factors, rather than considering PTSD symptoms in a reductionist way, and/or optimum treatment approach effectiveness measures for PTSD, which may aid in discovering those influences of client disengagement from PTSD therapies for sexual assault.

Current Context and Research on Client Disengagement from PTSD Therapy

Post-traumatic stress disorder (PTSD) develops following 'Exposure to actual or threatened death, serious injury, or sexual violence' (DSM-5, 2013). It is a disorder that can affect people of any age.

In order to contextualise sexual assault PTSD, the next section defines sexual assault. The development of recommended trauma-focused treatments (TFT) for PTSD is also outlined, along with an indication of where sexual assault PTSD sits within current research for PTSD therapy, and levels of disengagement from treatments.

Sexual Assault

The World Health Organisation (WHO) defines sexual assault as:

> Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work. (WHO, 2012, p. 2)

In 2018, the Office for National Statistics (ONS) Crime Survey for England and Wales (CSEW), reported:

- 20% of women have experienced some type of sexual assault since the age of 16, equivalent to 3.4 million female victims, and
- "3.1% of women (510,000) aged 16 to 59 had experienced a sexual assault in the last year.
  (ONS, 2018).

Survivors of sexual violence are at a higher risk of developing PTSD relative to survivors of other trauma types. It has been estimated that up to 94% of survivors of rape or sexual assault develop symptoms of PTSD in the first two weeks post assault, with around 50% of victims suffering long-term symptoms. Risk factors associated with the development of PTSD include reduced support network and comorbid conditions, such as depression and anxiety (PTSD UK, 2022).

The nature of the sexual assault event itself is a determinant of negative consequences for women's mental health. Post-assault functioning for victims of rape can have devastating consequences on victims' mental health (Vickerman and Margolin, 2009). For example, 30% of rape victims have had a major depressive episode, which is three times greater than that for non-victims of crime. Similarly, 33% of rape victims have contemplated suicide and 13% have attempted suicide (versus 8% and 1% for non-victims of crime) (Kilpatrick, Edmunds and Seymour, 1992, cited in Vickerman and Margolin, 2009). Additionally, sexual assault victims have three to 10 times higher rates of substance abuse than non-crime victims (Kilpatrick et al., 1992; Kilpatrick et al., 1997, cited in Vickerman and Margolin, 2009).

A study by Rees et al. (2011) on the prevalence of sexual assault and its relationship with mental health disorders, reported that from a total of 1218 women, 27.4% experienced at least one type of gender-based violence.[12] For women exposed to three or more gender-based violent attacks, this rose to 77.3%, and for women diagnosed with PTSD, it was 89.4%. Rees et al. (2011) also reported that sexual assault was associated with more severe mental disorders, higher rates of lifetime disorders and impaired quality of life.

A considerable body of research has demonstrated that women who experience sexual violence are at risk of developing PTSD. Tiihonen Möller, et al. (2014), in their research paper to identify risk of PTSD, found that of 317 female victims of rape,

[12] "Gender-based violence, which occurs in every country, territory, and region of the world, is a violation of basic rights that also prevents women from exercising their other social, economic and political rights. Globally, 35% of women have experienced physical and/or sexual violence." (https://www.unwomen.org/en/what-we-do/ending-violence-against-women/facts-and-figures).

39% had developed PTSD at six-month follow-up, and 47% suffered moderate to severe depression.

Client disengagement creates a number of challenges, both for the client and for mental health services alike **(**Saxon, Ricketts and Heywood, 2010). Often, clients who choose to disengage from PTSD therapy without resolution or symptom reduction can be placed at greater risk of longer-term suffering. For example, Saxon, Ricketts and Heywood (2010) suggested that measures of treatment effectiveness or client risk are difficult to assess for those clients who disengage from therapy due to lack of outcome assessment and evaluation. Where clients who disengaged have been followed up, data indicated that those who disengage earlier have poorer clinical outcomes, and those clients disengaging from therapy for reasons of dissatisfaction were reported to be significantly worse (Pekarik, 1992; Connell, Barkham and Mellor-Clark, 2008, cited in Saxon, Ricketts and Heywood, 2010).

The need for therapeutic interventions that meet the needs of the client with sexual assault PTSD is vital. However, it will be seen that much of the research generated for this review concerned empirically supported TFT within medical model approaches, from which issues of disengagement remain. The terms Empirically Supported Treatment (EST) and Evidence-Based Treatment (EBT) are used interchangeably in research literature, and without a clear definition or distinction of these two concepts, and for clarity, the acronym EST is used throughout this thesis (Drisko and Friedman, 2019).

Development of Current Trauma-Focused Psychological Therapies for PTSD

Research studies have shown that recent developments in EST for PTSD produce high numbers of clients disengaging from therapy (Cusack et al., 2016; Drisko and Friedman, 2019). This problem is compounded by a paucity of EST research in non-TFT approaches for treating PTSD generally, with even fewer research studies available for sexual assault PTSD, coupled with the difficulty of finding convincing

results for one specialist approach being more beneficial for the treatment of PTSD than another (Cusack et al., 2016).

Previous studies in the field have approached client disengagement from TFT approaches in a number of ways, incorporating a range of measures and methods that have produced mixed results and conflicting treatment recommendations. For example, Schottenbauer et al. (2008) reviewed disengagement rates in 55 studies of TFT approaches for PTSD. Their findings recognised the need for a standardised method to help identify predictors of disengagement, since methodological inconsistencies in the literature made comparisons across studies difficult. Disengagement rates in some studies ranged widely (the authors suggested this may be linked to different study populations), and some studies were also found to have disengagement rates from TFT as high as 50% (Schottenbauer et al., 2008).

Current measures for researching client disengagement from PTSD therapy have not made a discernible reduction in disengagement rates: on the contrary, evidence from current research suggests TFT approaches continue to be afflicted with high rates of disengagement (Shnaider et al., 2014; Lee and Bowles, 2020). Research recognises contentious issues surrounding individuals tolerating the exposure component of TFT approaches, which can lead to high disengagement rates. Lee and Bowles (2020) propose alternative treatment options that do not focus on trauma memory processing might be more accessible for individuals who do not wish to process the trauma memory. Non-TFT approaches, such as interpersonal psychotherapy (IPT) and person-centred therapy (sometimes called present-centred therapy) (PCT) have demonstrated clinical effectiveness, including outcomes equivalent with TFT in some comparison studies, for example, Proenca et al. (2019). An alternative direction for research on disengagement might focus on the narratives of clients who disengage from TFT, in evaluating their experience of treatments and preferred treatment options, to develop a body of research for effective approaches for PTSD that evidence why they work, and for whom they work (e.g., trauma type).

The literature search yielded an extensive range of recommended TFT approaches for PTSD (Lee and Bowles, 2020), though the search was further burdened by the lack of an agreed definition for disengagement. For this literature review alone, there were

several, including: attrition, premature termination, unilateral termination, retention, discontinuation, and the most used, drop out. In the absence of an agreed definition of disengagement, researchers tend to define their own parameters of disengagement for their research. For example, even though most studies defined disengagement as leaving therapy before a specified number of sessions, the actual cut-off varied across and within studies (Barrett et al., 2008). Whilst one study defined disengagement when two consecutive sessions were missed (Hatchett, Han and Cooker, 2002), another defined it as a failure to return after initial assessment (Hampton-Robb, Qualls and Compton, 2003), where findings revealed 37% (n=397) of prospective clients did not attend their first session. Lack of a standard definition of disengagement generates both inconsistency and possible contradictory methods in research, which may result in confounding outcomes for disengagement (Barrett et al., 2008).

Some studies compared PTSD symptom improvement/worsening; while other studies compared PTSD with/without co-morbidity;[13] and with severity of PTSD symptoms (Lee, Faber, and Bowles, 2021). Further examples of research studies for PTSD treatment approaches and disengagement include number of sessions and/or timing of disengagement (Gutner et al., 2016), and comparing one or two TFT approaches for superiority of one trauma model over another (Greenwald, McClintock and Bailey, 2013; Jayawickreme et al., 2014; Wells et al., 2014). EST for PTSD are recommended in the literature, though often without clarification of what TFT approach is effective for different trauma types, and with what population (e.g., children, adults, single trauma event, long-term complex trauma, etc.) (Lee, Faber, and Bowles, 2021).

Moreover, only those recommended EST approaches for PTSD were validated and emphasised in the current literature. For example, a search of the literature yielded only four articles for non-TFT approaches to treat PTSD: Campanini et al. (2010) and Proenca et al. (2019) utilised Interpersonal Therapy (IPT) for PTSD, whereas Kelly and Garland (2016) and Müller-Engelmann et al. (2017) used Mindfulness-Based Stress Reduction (MBSR) as a standalone treatment approach for PTSD. Four articles combined TFT with non-TFT approaches as an adjunct, examining whether the

[13] The simultaneous presence in an individual of more than one illness, disease, or disorder (APA Dictionary of Psychology, 2020).

trauma exposure component of TFT impacted client disengagement. These were Frye and Spates (2012), who compared Prolonged Exposure (PE) with mindfulness and emotional regulation; Bryant et al. (2013), who used CBT and emotional regulation; Butollo et al. (2014), adopted CBT and Dialogical Exposure Therapy (DET), and Zepeda Méndez et al. (2018), focused on EMDR and Trauma-Informed (TI) Yoga. The review yielded six articles of TFT approaches for PTSD and therapist effect, which were: van Minnen, Hendriks and Olff (2010), Silveira Júnior et al. (2011), Ehlers et al. (2013), Jayawickreme et al. (2014), Keefe et al. (2018) and Proença et al. (2019). Only one article, which is more than 10 years old, van Minnen, Hendriks and Olff (2010), incorporated client treatment preferences in TFTs for PTSD in their study.

Research examining disengagement for sexual assault PTSD produced 12 reports from a review of the literature: only one, Frye and Spates (2012), was qualitative, with the remaining 11 being quantitative. Of those 11, Keefe et al. (2018) researched disengagement from EST comparing TFT PE and Cognitive Processing Therapy (CPT), and five articles researched disengagement from TFT PE, CPT or EMDR and symptom change, including Jayawickreme et al. (2014), Schnaider et al. (2014), Larsen et al. (2016), Szafranski et al. (2017), and Haven et al. (2021). Two articles, Markowitz et al. (2017) and Frye and Spates (2012), compared disengagement from TFT PE with two non-TFT; IPT and Relaxation Therapy (RT), and PE with Mindfulness (MBSR) and Emotional Regulation, respectively. Gutner et al. (2016) examined when disengagement occurs during PE therapy. Hendricks et al. (2018) assessed intensive PE (iPE) and disengagement. Only two articles: Kelly and Garland (2016) and Proença et al. (2019) researched disengagement from sexual assault PTSD treatment utilising the non-TFT MBSR and IPT, respectively. Thus, 12 studies in total for sexual assault PTSD and disengagement were included and critiqued for this literature review.

Literature Review Methods

As previously mentioned, this review used PRISMA guidelines (Page et al., 2021) to structure and shape the methodology for a systematic review of the current literature available for sexual assault PTSD and disengagement.

Search Strategy

The search used five online databases: PsycInfo, PsycArticles, Academic Search Complete (EBSCO), SCOPUS and Web of Science. The first step identified key words from the research question to select key concepts. Boolean operators and/or were used and the terms entered enabled a focus on key words that were central to the main concepts in the research question, targeting the most focused results. The asterisk wildcard symbol was used to further broaden the search terms, for example, drop* was used to broaden the search for disengagement, for example:

therapy or psychotherapy or counseling or counselling

AND/OR: ptsd or post traumatic stress disorder or posttraumatic stress disorder or post-traumatic stress disorder

AND/OR: drop-out or patient dropout or premature termination or unilateral termination or attrition or drop*

AND/OR: sexual assault or rape or sexual violence or sexual trauma

The Advanced Search option captured more specific results by selecting to search the full text of articles. Snowballing supplemented a small yield, focusing on the most current and relevant references.

Limiters, such as peer-reviewed journals only, were also used to limit the search to more specific literature. Literature searches were further refined for publication dates using Refine Results so that only articles written in the English Language and

between the years 2010 – 2021 were selected. This ensured that only current and contemporary publications were captured.

Study Eligibility

The search focused on disengagement from sexual assault PTSD therapy for female adults over 18 years. Disengagement from PTSD psychological therapies for all types of traumas was also included, in order to augment a poor yield. A full list of the inclusion and exclusion criteria for eligibility of the literature review is outlined in Table 1 (Appendix 6).

Table 1: Literature review inclusion and exclusion criteria

Inclusion Criteria	Exclusion Criteria
Full-text articles	Abstract only
Peer-reviewed journals	Non-peer-reviewed journals
Written in the English Language	Not written in the English Language
Female population	Not female population
Sexual assault	Nonsexual assault
Adult population over 18 years	Non-adult population over 18 years
Publication date 2010 - present	Publication date before 2010
Research relevant to disengagement from PTSD therapies	Research not relevant to disengagement from PTSD therapies

Data Extraction and Quality Assessment

The search yielded 35 articles. Figures 1, 2, and 3 provide a PRISMA 2020 flow diagram for each of the database searches, including records identified, screened, and included/excluded. Total number of records before screening was 1211, and total records screened was 92. Records excluded comprised duplicates, research on veterans and PTSD, children and adolescents and PTSD, and reports not relevant to disengagement from PTSD therapy. The peer-reviewed Critical Appraisal Skills Programme (CASP, 2018) checklist (Appendices 7a and 7b) for screening research

was used to gauge suitability of the selected literature and to ensure the focus of the articles was relevant to the research question.

Grey literature from UK Government departmental websites and professional organisations such as NICE Guideline Methods, evidence and recommendations, the ICD-10 (2019) and The Diagnostic and Statistical Manual of Mental Disorders (DSM-5, 2013) handbook for descriptions, symptoms, and other criteria for diagnosing mental health disorders, were also used.

In total, this review comprised mostly of EST research studies for PTSD and disengagement, which included 21 (56%) of 35 randomised controlled trials (RCT). The review was categorised into five areas of research for PTSD treatment and disengagement as follows: (1) empirically supported TFT for PTSD and disengagement; (2) empirically supported TFT versus non-TFT for PTSD and disengagement; (3) empirically supported TFT for PTSD related symptoms (for example, avoidance, anxiety, hyperarousal) and disengagement; (4) TFT for intensity, duration or session dose for PTSD and disengagement; and (5) PTSD treatment with non-TFT and disengagement.

Although the articles are presented in five separate categories, overlap is possible, since some articles could sit within two categories of PTSD research. For example, van Minnen, Hendriks and Olff (2010) and Jayawickreme et al. (2014) are presented in category (3) but might also have been presented in category (1) since both consider TFT and disengagement, however the studies also include clinicians' under-utilising TFT due to concerns of client symptom worsening. In the main, the articles are organised based on findings relevant to those TFT recommendations for PTSD and disengagement, and represent a synthesis of all relevant, contemporary articles for PTSD therapy treatment and disengagement.

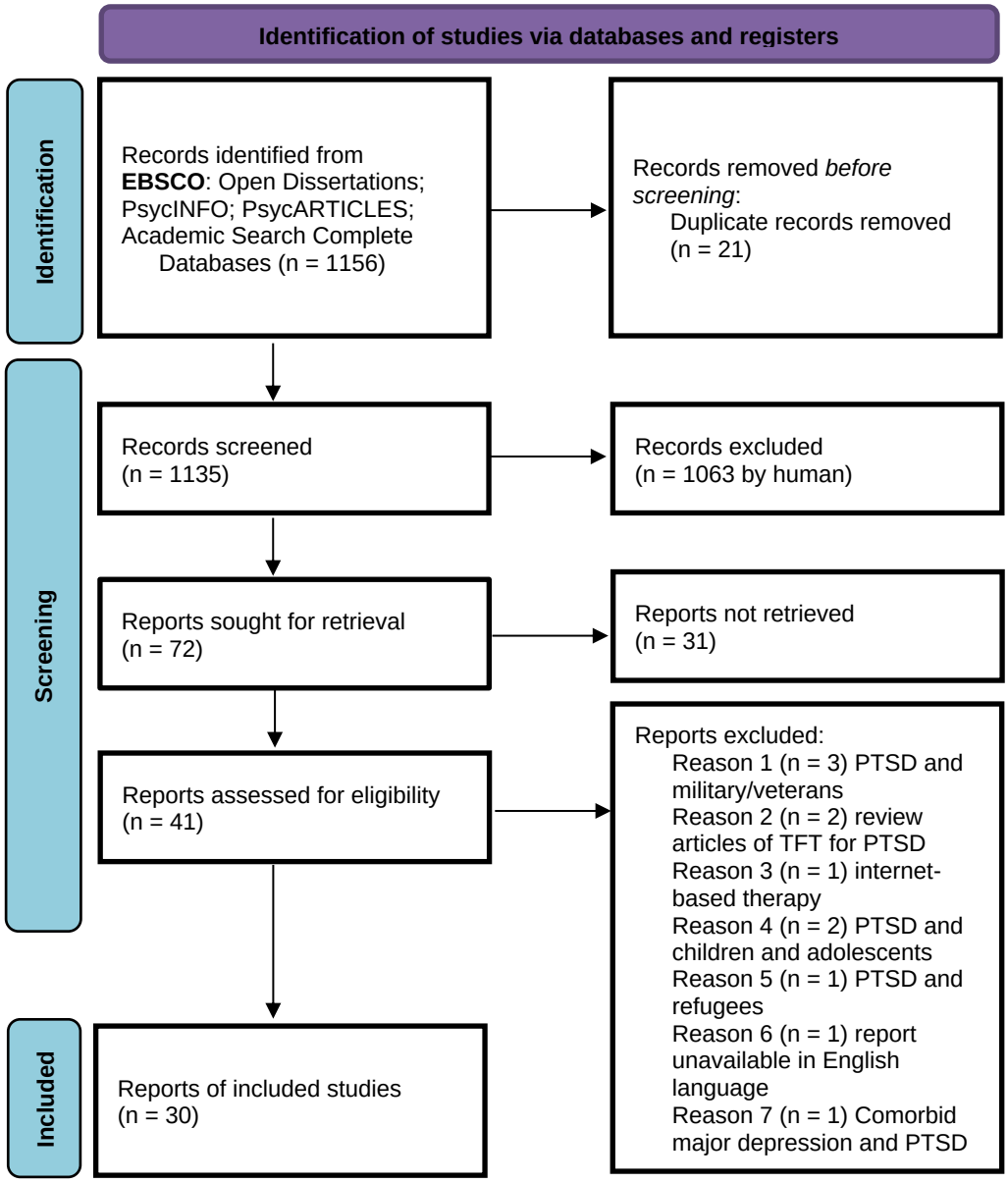


Figure 1. PRISMA Flow diagram for EBSCO databases (Page et al., 2021)

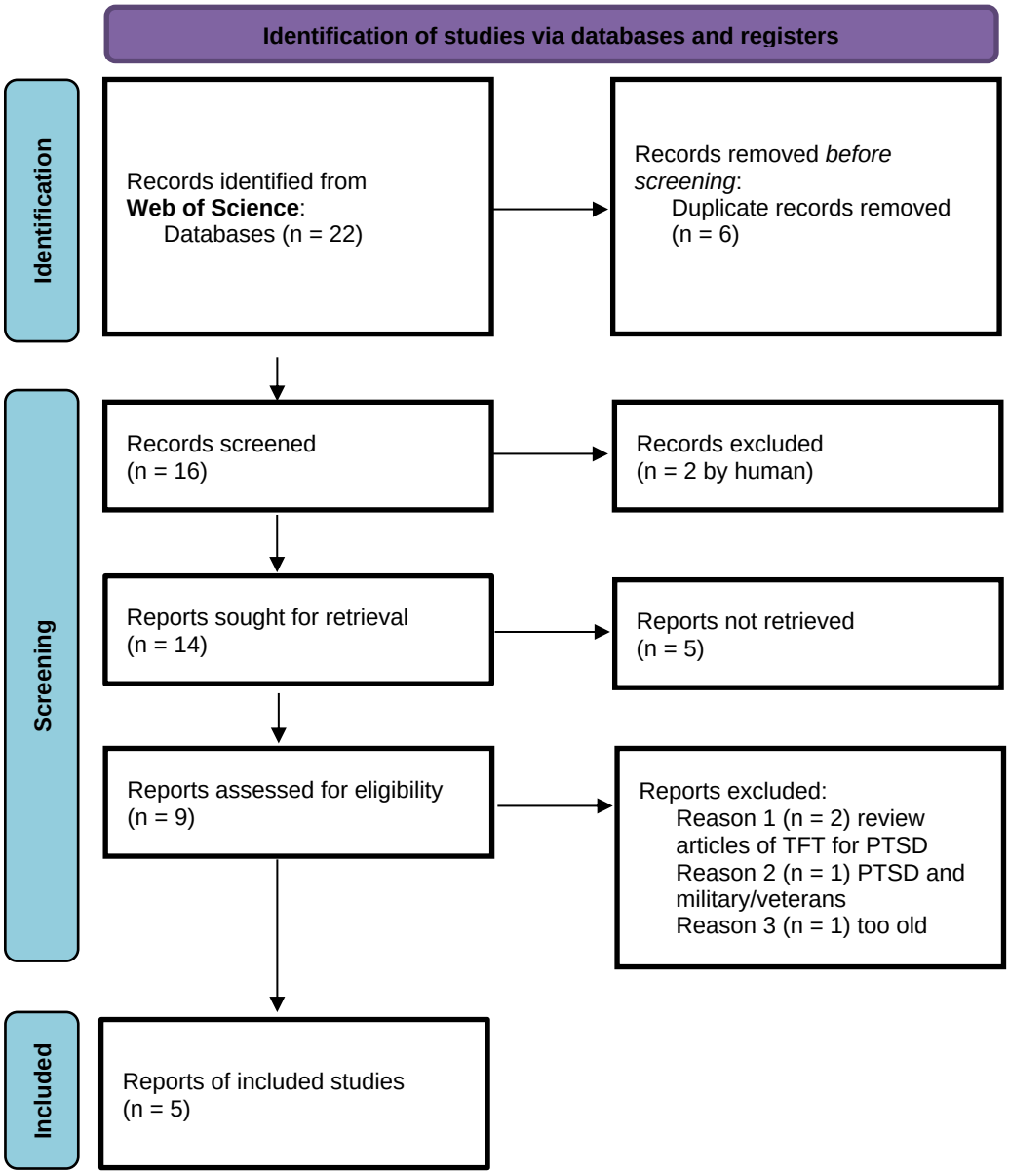


Figure 2. PRISMA Flow diagram for Web of Science database (Page et al., 2021)

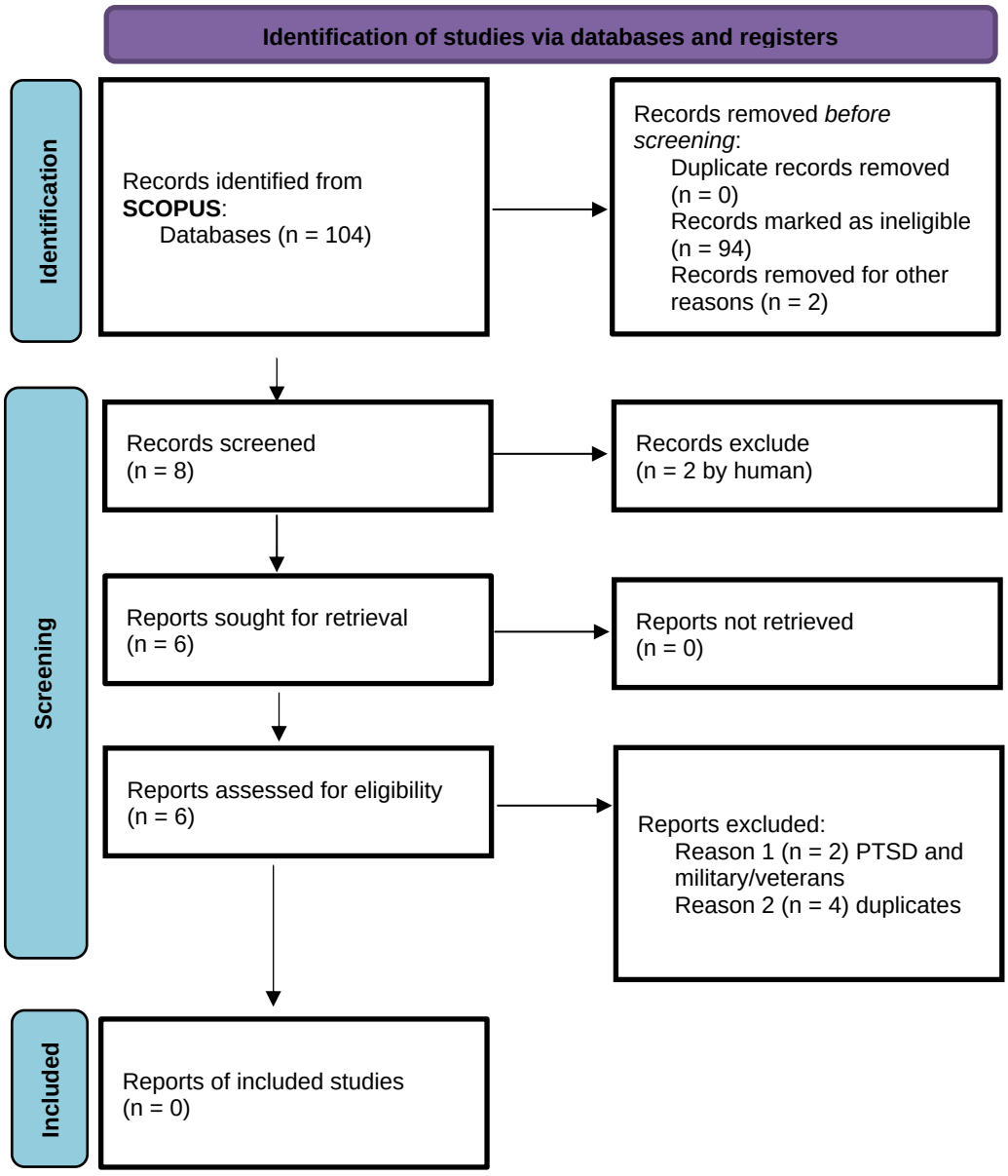


Figure 3. PRISMA Flow diagram for SCOPUS database (Page et al., 2021)

TFT and non-TFT therapy terms and definitions, including a brief description, is provided in Appendix 1. Psychodynamic therapy (PDT) and defence mechanism terms and definitions are provided in Appendix 2 and 3, respectively.

Review Results

(1) TFT for PTSD and Disengagement

Greenwald, McClintock and Bailey (2013) pilot study compared two TFT for PTSD. Nineteen participants with a single-incident trauma were randomly assigned to EMDR (n=10) or brief-Progressive Counting therapy (PC), (n=9). A total of 15 participants completed treatment to the study's termination criteria (session 3) or until the final, session 4. In the PC cohort, three of nine participants dropped out, and in the EMDR condition, one of 10 dropped out (Greenwald, McClintock and Bailey, 2012). At 12-week follow-up of those participants who met the criteria for PTSD diagnosis at pre-treatment (40%), four EMDR participants and one of the two PC participants, no longer met the criteria (Greenwald, McClintock and Bailey, 2012). The authors suggested their preliminary findings indicated that PC is a sustained, effective trauma treatment (Greenwald, McClintock and Bailey, 2013).

Larsen et al. (2016) investigated symptom worsening in three TFT for PTSD, comparing PE, CPT, and a version of CPT (CPT-C, which excluded the written trauma narrative component of CPT). Females (n=192) diagnosed with sexual assault PTSD were assessed to identify whether the trauma processing component in TFT is linked to symptom worsening or increased disengagement. Their study examined symptom worsening at any point in the treatment (of 12 sessions). Findings were similar across the treatments, with the three different levels of the exposure component showing symptom worsening in all three TFT at session 4; fourteen participants in the sample (7%) experienced symptom exacerbation: nine in CPT, one in CPT-C, and four in PE, and four of the 14 disengaged from treatment (Larsen et al., 2016). Those who experienced symptom worsening did not disengage at higher rates than those who did not experience symptom worsening, however, those who experienced symptom worsening were more likely to have PTSD symptoms post-

treatment (Larsen et al., 2016). It should be noted that symptom worsening in the CPT-C treatment experienced the lowest outcomes (n=1), which excluded the written trauma narrative component of CPT. The authors suggested that overall, findings demonstrated that TFT can be tolerated without symptom worsening (Larsen et al., 2016).

Larsen et al. (2016) also examined whether predictions could be made about clients most likely to experience symptom worsening. Using client demographics such as trauma-related variables, treatment and diagnostic variables, and avoidance symptoms (a pre-treatment assessment score was used), findings suggested that the demographic variables examined did not predict symptom worsening (Larsen et al., 2016).

In a comparison study of two TFT: PE and CPT for sexual assault PTSD, Keefe et al. (2018) concluded that, despite equivalent disengagement rates across both treatments, individual differences among clients affected the likelihood of completing a particular treatment. Here, 20 participants were randomly assigned to one of the treatments. Predictors of treatment completion included a selection of client characteristics such as demographics (age, race, education background, etc.), interpersonal history, PTSD symptoms and comorbid symptoms (for example PTSD and depression). Individual differences such as trauma type, current relationship conflict, or being in a racial minority, indicated disengaging from treatment irrespective of treatment modality. The authors suggested that current relationship abuse predicted increased disengagement rates from PE compared to CPT, which may be due to difficulty in tolerating the exposure component of PE. The role of race predicting disengagement from PE could be due to several reasons, including cultural differences that may have impeded perceived credibility of exposure-focused treatments, and the exclusively white clinicians in their trial (Keefe et al., 2018).

Keefe et al. (2018) further proposed that client disengagement from PTSD therapy may be due in part to therapists' 'intuition' regarding the best treatment for clients. However, with little systematic data or comparative studies to draw on as evidence, this proved difficult for them to substantiate (Keefe et al., 2018). To understand what is considered best practice for clients presenting with symptoms of PTSD, the authors suggest an appraisal of both the TFT approach utilised, and the skills that therapists

use to help reduce clients' symptoms. Systematic data that support therapist's judgement of the superiority of one PTSD treatment approach over another, may contribute to reducing levels of client disengagement (Keefe et al., 2018).

In order to enhance treatment completion, Alpert et al. (2020) attempted to identify client factors that predict disengagement. Disengagement rates have been associated with PTSD symptoms such as pre-treatment avoidance, re-experiencing, hyperarousal symptoms, catastrophic cognitions, and impaired social functioning (Alpert et al., 2020). The study included 51 adults with PTSD receiving CPT who were examined for predictors of disengagement by coding the content of trauma narratives written in early CPT sessions (Alpert et al., 2020). Findings indicated 16 participants (31%) disengaged from CPT, and of those, 76.0% did so by session five. Of the 11 participants who provided feedback on their reason for disengagement, 82% reported that CPT was too distressing (Alpert et al., 2020). Participants' narratives, written during treatment, were also coded for trauma content responses. Exploring negative emotions, and ruminative[14] processing expressed in the narratives, indicated positive outcomes for completion of treatment (91% less likely to disengage). In contrast, negative physiological experiences[15] and overgeneralisation[16] were associated with a 3.72 times higher likelihood of disengaging from treatment (Alpert et al., 2020).

Despite the development of recommended EST psychological therapies for the treatment of PTSD, it is evident from the literature review that disengagement rates for TFT remains a persistent concern **(**Foa et al., 2005, cited in Lewis et al., 2020). A systematic review by Lewis et al. (2020) of recommended PTSD treatments examined differences in client disengagement rates from across all TFT for PTSD modalities, and possible explanations. From 28 psychological therapies for PTSD that were evaluated; eight of which were CBT with a trauma focus. Findings indicated that

[14] Rumination is obsessional thinking involving excessive, repetitive thoughts or themes that interfere with other forms of mental activity. It is a common feature of obsessive-compulsive disorder and generalised anxiety disorder (APA Dictionary of Psychology, 2020).
[15] Physiological arousal refers to aspects of arousal shown by physiological responses, such as increases in blood pressure and rate of respiration and decreased activity of the gastrointestinal system. Such primary arousal responses are largely governed by the sympathetic nervous system, but responses of the parasympathetic nervous system may compensate or even overcompensate for the sympathetic activity (APA Dictionary of Psychology, 2020).
[16] Overgeneralisation is a cognitive distortion in which an individual views a single event as an invariable rule, so that, for example, failure at accomplishing one task will predict an endless pattern of defeat in all tasks (APA Dictionary of Psychology, 2020).

those psychological therapies with a trauma focus were associated with greater disengagement: a dropout rate of 18% from those with a trauma focus, as opposed to 14% from those without a trauma focus. The authors suggested client difficulties in tolerating TFT as one explanation for the higher rate of disengagement.

Storm and Christensen's (2021) study compared the outcomes of studies for treatment by CBT and medication to assess whether pharmacotherapy (medication therapy) and psychotherapy combined are a more effective treatment than therapy alone for effective PTSD symptom reduction. Secondly, they assessed whether any differences in disengagement rates between these two treatments were found. Seven studies were identified for comparison: three studies showed that psychotherapy was more effective than SSRI antidepressant medication;[17] two studies showed a positive effect with SSRI and PE, and two studies showed no difference in outcomes for the treatment groups (Storm and Christensen, 2021). In four of the included studies, clients treated with psychotherapy were more likely to disengage. However, the results were inconclusive due to differences in treatment duration, follow-up, trauma types and disengagement rates across studies (Storm and Christensen, 2021).

(2) TFT versus non-TFT for PTSD and Disengagement

Concerns regarding PE for the treatment of PTSD due to symptom worsening during exposure to trauma, generate poor outcomes to the treatment (Frye and Spates, 2012). Early disengagement is suggested to occur in PE due to clients' reluctance and avoidance of trauma-related experiences that occur during treatment (Frye and Spates, 2012). Frye and Spates (2012) applied two non-TFT for sexual assault PTSD: mindfulness and emotion regulation skills, during PE treatment, to augment clients' stabilisation for the exposure phase of PE and reduce clients' attempts to escape, avoid, or control anxious arousal during treatment. In this single case study, the client completed mindfulness and emotion regulation skills training prior to completing 10 sessions of PE. Imaginal Exposure therapy (IE) was practiced six times in sessions

[17] SSRI: selective serotonin *r*euptake *i*nhibitor is any of a class of antidepressants that are thought to act by blocking the re-uptake of serotonin into serotonin-containing presynaptic neurons in the central nervous system (APA Dictionary of Psychology, 2020).

five to 10. During the first four sessions of IE (sessions five to eight), the client's SUDS[18] ratings on a 10-point scale ranged from nine to five. Once the client engaged in the training exercises, the SUDS rating reduced to three (Frye and Spates, 2012). ASI[19] scores at sessions five and seven were 18 and 20, and lower than the client's pre-treatment scores (21). The client's SUDS score reduced to a five rating in the final two sessions of IE (sessions nine and 10), and SUDS ratings for the final IE exercise started at four and ended at two. At the end of treatment, post-treatment CAPS[20] weekly and monthly scores reduced to four and 18 respectively, and no longer met the criteria for PTSD. Scores were maintained at three months' follow-up showing CAPS weekly and monthly scores respectively, at nine and 13, and still no longer meeting the criteria for PTSD (Frye and Spates, 2012). The authors stated that clients with high anxiety sensitivity are unable to tolerate exposure, however, data presented in this case study suggested that skills training in mindfulness and emotion regulation played a role in the reduction of anxiety sensitivity (Frye and Spates, 2012). The authors suggested that more research is needed to determine whether these same findings would occur with PE treatment alone, or whether mindfulness, emotion regulation, and PE integration is necessary to increase the tolerability of PE.

Research suggests that some TFT increase disengagement from treatment for PTSD due to the distress they cause to individuals who cannot tolerate the trauma component of the treatment (Bryant et al., 2013). Imel et al., (2013) conducted a meta-analysis to compare disengagement rates between TFT and non-TFT. When directly compared, different TFT approaches did not predict disengagement across studies or between studies. However, three of the 17 TFT included in their study restricted the discussion of the trauma memory component from the treatment. When PCT (trauma focus restricted) was compared with TFT, there was evidence that disengagement was lower in PCT compared to TFT. Imel et al. (2013) acknowledged that TFT focus on emotional processing through exposure to the trauma memory, which is the primary therapeutic component of TFT, and thus their findings are not surprising in terms of trauma avoidant individuals and higher rates of disengagement from TFT.

[18] The Subjective Units of Distress Scale (SUDS) is a rating scale that ranges from 0 = no anxiety, to 10 = extreme anxiety.
[19] Anxiety Sensitivity Index (ASI).
[20] Clinician Administered PTSD Scale (CAPS) refers to weekly and monthly total severity scores.

Recommended treatment for PTSD is predominantly TFT CBT, while other approaches are under-represented. In Butollo et al., (2013) pilot study in an outpatient setting, 25 females diagnosed with PTSD were treated with 13, once-a-week Dialogical Exposure Therapy (DET) sessions, combined with CBT. Twenty-one clients completed the therapy, and results indicated a significant reduction in client-rated PTSD symptom improvement for pre and post treatment. Of the 21 who completed, 43% showed reliable improvement, and 57% showed no improvement (Butollo et al., 2013). Disengagement rate was 16% (n=3). The authors suggested that symptom improvement and low disengagement rate for DET combined CBT therapy, requires further research as a treatment for PTSD (Butollo et al., 2013).

Wells et al. (2014) compared Metacognitive Therapy (MCT) with PE therapy in 32 participants with PTSD. Participants were assigned to either eight sessions of therapy (MCT or PE) or an 8-week wait period (WL). Results indicated that both treatments were effective, resulting in significantly lower symptoms of PTSD, anxiety and depression, compared with the WL. MCT was more effective than PE on self-report symptoms of PTSD and superior to WL group (Wells et al., 2014). Only one participant disengaged from each treatment group, showing both treatments as effective, but MCT had a clear advantage. The authors suggest that these results indicated that MCT could be a highly effective and more rapid alternative to exposure-based PTSD treatments in larger-scale study trials (Wells et al., 2014).

There remains a lack of research addressing the effect of trauma type in psychotherapy for PTSD, and psychotherapeutic approach (Markowitz et al., 2016). Markowitz et al. (2017) compared three different psychotherapeutic approaches to PTSD. Clients who had experienced sexual, physical, and interpersonal trauma derived PTSD, and presenting a range of multiple traumas, were randomly assigned to three psychotherapeutic approaches for 14 weeks of treatment: PE (n=38); IPT (n=40); or relaxation therapy RT (n=32). All treatments showed benefit at 14 weeks for non-sexual assault clients, with IPT showing equivalent effectiveness to PE and lower disengagement rates compared to PE and RT for clients with sexual assault PTSD. PE produced negative outcomes for clients with sexual trauma compared to PE clients with sexual trauma (Markowitz et al., 2017). The authors suggested that IPT

focus on feelings to help clients understand relationships and gauge trust in others may be a better match for sexually violated clients, than PE gradual exposure focus of sexual assault, trauma-related memories (Markowitz et al., 2017).

Paintain and Cassidy's (2018) qualitative review sought to identify studies comparing the effectiveness of Psychodynamic Therapy (PDT) and CBT therapies in the treatment of PTSD. Only two studies in the review directly compared CBT and PDT for treatment effectiveness of PTSD, where PDT was found to be equally or more effective than CBT and was associated with greater reductions in PTSD. Disengagement from exposure components in TFT is often cited as the principal reason for the underutilisation of CBT **(**Imel, et al, 2013). Between 16% and 21% of studies reported high disengagement rates in most studies utilising a CBT treatment approach (Paintain and Cassidy, 2018). In studies that included both CBT and PDT treatment groups, disengagement rates were either comparable or greater in the PDT group (Paintain and Cassidy, 2018). Although findings supported PDT as an effective therapy for PTSD, studies indicated CBT was more effective for the treatment of PTSD. For example, Gilboa-Schechtman et al. (2010) study reported that CBT led to a larger mean reduction in PTSD symptom scores compared to PDT, with 19.4 and 10.8 respectively (Gilboa-Schechtman et al., 2010). Paintain and Cassidy (2018) proposed that the development of treatments that promote tailoring interventions according to client needs are the most likely to result in improvements in outcomes that reflect EST recommendations for the most effective treatment approach for PTSD **(**Paintain and Cassidy, 2018).

Belsher et al. (2019) study sought to determine whether Present-Centred Therapy (PCT), a non-TFT for PTSD, was more effective in reducing symptoms compared to TFT CBT, and whether PCT was associated with lower treatment disengagement rates compared to TFT CBT, to establish whether clients disengaged from non-TFT PCT at lower rates relative to TF-CBT (Belsher et al., 2019). Twelve studies were selected for comparison (n=1837), of which three compared PCT to a wait-list group (WL), or minimal attention group (MA), and 11 compared PCT to TFT CBT. PCT was found to be more effective than the WL group in reducing PTSD symptom severity. PCT results indicated approximately 14% lower treatment disengagement rates compared

to TFT CBT. From a comparison of 12 studies, the authors concluded that PCT was a less effective treatment in reducing PTSD symptom severity at post-treatment, but PCT showed reduced treatment disengagement rates compared to TFT CBT (Belsher et al., 2019).

The therapeutic relationship is a strong predictor of disengagement from psychological therapies (Sharf, Primavera and Diener, 2010, cited in Sijercic et al., 2021). Sijercic et al. (2021) study examined the association between therapeutic relationship and treatment disengagement for effectiveness in 12 weeks of CPT for PTSD. Among 167 participants, the study investigated whether therapeutic relationship was significantly associated with disengagement from CPT treatment, and when disengagement from treatment occurred, for example, at the start (i.e., initial alliance), or at the end (i.e., later alliance), and the average alliance across the 12-week treatment period (Sijercic et al., 2021). An average of 33.1% of clients disengaged over the course of CPT treatment; almost half of those clients disengaged within the first six sessions. The authors suggested further research on differences in early compared to late alliance development and session disengagement in CPT, would be advantageous (Sijercic et al., 2021).

(3) TFT for PTSD Related Symptoms, and Disengagement

van Minnen, Hendriks and Olff (2010) investigated the under-utilised choices by therapists of recommended TFT exposure therapies for clients with PTSD in an attempt to find an explanation for the minimal use of EST IE (van Minnen, Hendriks and Olff, 2010). The 255 trauma professionals were presented with four treatment options. The study aimed to examine which therapist and client factors promoted or inhibited professionals' choice of IE (van Minnen, Hendriks and Olff, 2010). The four treatment options included IE (or another CBT exposure therapy of choice), supportive therapy, EMDR and medication. IE was found to be underutilised by trauma professionals in the study (van Minnen, Hendriks and Olff, 2010). Trauma professionals were less well trained in exposure-based treatments (less well trained in IE than in EMDR and supportive counselling), but better trained in IE than in prescribing medication (van

Minnen, Hendriks and Olff, 2010). Professionals' perceived barriers to IE, such as a fear of symptom exacerbation and disengagement, were negatively related to choosing IE when clients presented with multiple traumas (van Minnen, Hendriks and Olff, 2010). The authors encouraged comprehensive training in this technique to focus both on the application of the technique and address the generally low credibility and misperceived barriers, such as apprehension around symptom exacerbation and disengagement with TFT (van Minnen, Hendriks and Olff, 2010).

Bryant et al. (2013) proposed that CBT for PTSD involved some form of exposure (confronting the trauma) in therapy, which can precipitate high levels of disengagement due to client avoidance. They suggested that pre-treatment training in emotion regulation might enable participants to more effectively manage any distress caused by exposure (Bryant et al., 2013). Seventy clients with PTSD were randomised to 12 sessions of either supportive counselling followed by CBT (support/CBT), or emotion regulation training followed by CBT (emotion/CBT). Findings supported emotion/CBT (31%), which achieved greater symptom functioning at follow-up than clients in support/CBT (12%). The authors suggested that client response to CBT may be improved in PTSD when they are prepared with emotion regulation skills. Fifty-one (73%) completed treatment and 32 (46%) completed the six-month follow-up assessment. The authors suggested the high number of participants who disengaged from the study at six-month follow up might be due, in part, to the exposure component of CBT that typically elicits distress in PTSD clients (Bryant et al., 2013). Research has evidenced that exposure components in TFT do not result in greater disengagement or adverse reactions than other therapy techniques (Foa et al., 2002, cited in Bryant et al., 2013), however, the authors suggest that emotion regulation skills used in managing distress may enable some clients to tolerate these reactions and benefit more from CBT (Bryant et al., 2013). Although outcomes resulted in less treatment disengagement and a reduction in the PTSD symptoms of anxiety and negative cognitions, the small proportion of those participants that completed the treatment emphasised that outcomes should be considered moderate (Bryant et al., 2013).

Although TFT are recommended ESTs for PTSD, the positive outcomes observed in research may not generalise to a wider range of trauma 'types' and presentations seen

in clinical practice. Ehlers et al. (2013) investigated whether Cognitive Therapy (CT) for PTSD can be effectively implemented in a UK National Health Service (NHS) outpatient Clinic in an ethnically diverse area. Presenting with a range of trauma types, 330 clients with PTSD were treated by 34 therapists who had received training and supervision in CT-PTSD. The majority of patients showed increased symptom improvement from 78.8% to 84.5%; and clinically significant change, from 57.3% to 65.1%. (Ehlers et al., 2013). Symptom worsening was observed in only 1.2% of clients, and no therapist effects were significant, although there was a trend for inexperienced therapists to achieve fewer good outcomes than experienced therapists (Ehlers et al., 2013).

Disengagement rates were low, with an overall disengagement rate of 13.9%, (46 of 330 clients). Of these, six clients (13%) disengaged after one session, 11 (23.9%) after two sessions, eight (17.4%) after three sessions, four (8.7%) after four sessions, seven (15.2%) after five sessions, four (8.7%) after six sessions, and six (13.0%) after seven sessions (Ehlers et al., 2013). Clients who disengaged had waited longer for treatment, and of these, only 8.7% (4 of 46) showed a clinically significant treatment response, compared to 66.9% (190 of 94) of clients who completed treatment. The authors concluded that low disengagement rates supported the treatment of CT-PTSD for clients and could be utilised in routine clinical services treating clients presenting with a wide range of trauma types (Ehlers et al., 2013).

Jayawickreme et al. (2014) found clinicians were under-utilising PE for PTSD due to concerns of symptoms worsening. In their study, 361 female assault survivors with PTSD were randomly assigned to PE, waitlist (WL), CPT, EMDR, or a combination of PE, plus stress inoculation training (SIT), or PE plus cognitive restructuring, to evaluate those participants who showed symptom worsening or improvement. Disengagement rate from the four different treatments included in the study was 25.8%, which was significantly higher than 10.7% dropouts for WL (Jayawickreme et al., 2014). Disengagement rates were highest for the PE treatment. There were no significant differences in PTSD symptom improvement or worsening among the different treatments. The exact pattern of results was observed when PE alone was compared to WL. Findings indicated positive improvement for both PTSD and

depression when compared to WL, concluding that PE and other TFT were effective treatments for PTSD (Jayawickreme et al., 2014).

In their study of 78 women with PTSD, Shnaider et al. (2014) compared the treatment effectiveness of CPT without the written accounts (CPT-C), against CPT with written accounts. The aim was to determine whether outcomes in psychosocial functioning (an individual's ability to perform daily living activities and to engage in relationships, etc.) were associated with changes in PTSD symptoms for female survivors of interpersonal violence. Improved functioning results were similar across both the treatment groups. Additionally, clinician-assessed PTSD symptom reduction was associated with outcomes in all domains of functioning (.44 to .68) (Shnaider et al., 2014). All areas of psychosocial functioning improved following completion of the CPT (with and without written accounts), indicating that outcomes in psychosocial functioning may be associated with improvements in a range of PTSD symptoms (Shnaider et al., 2014).

A common opinion among researchers is that individuals who disengage from PTSD treatment do not show symptom improvement (Szafranski et al., 2014). Szafranski et al. (2017) examined PTSD and depression symptom change among women who disengaged from CPT prior to treatment completion, to assess what proportion of those that disengaged experienced PTSD and depression improvement. An examination of the differences between those that disengaged and responded to treatment versus those that did not, was further examined by comparing client demographic information. Females (n=321) diagnosed with sexual assault PTSD participated in two randomised clinical trials examining PTSD treatment outcomes; 53 participants disengaged from the study. Results demonstrated considerable numbers of disengaged participants showed significant improvement for PTSD and depression (Szafranski et al., 2017). Findings for PTSD symptoms revealed 37.74% (n=20) of participants showed improved symptoms. In terms of demographics, participants in the PTSD improved outcomes group were younger in age, attended more treatment sessions than participants in the no-symptoms change group, reported more years of completed education, more months since the assault, were more likely to be white, and more likely to be married/partnered with a higher household income, compared to the PTSD no-symptom change group (Szafranski et al., 2017). The

authors suggested the possibility that a shorter learning history meant symptoms were less embedded in younger participants, allowing for more cognitive flexibility and quicker adaptations during treatment. Results also revealed a minimum session attendance (e.g., six sessions) for participants to obtain significant symptom reduction (Szafranski et al., 2017).

EST therapies have been developed to treat PTSD, yet issues remain regarding access to these treatments, disengagement rates and lack of adequate dissemination and implementation in some resource mental health settings (Booysen and Kagee, 2020). To address some of these issues, Booysen and Kagee (2020) began exploring the effectiveness of administering brief trauma therapies to avoid potential financial or logistical constraints that affect individuals accessing treatment. PE usually comprises eight to 15 sessions, though research has evidenced that less than 10% of PTSD clients complete eight sessions (Tuerk et al., 2013). Booysen and Kagee's (2021) study examined treatment outcomes and effectiveness of six sessions of PE for PTSD and co-morbid depression and anxiety. The authors speculated that clients who received at least six sessions of PE would have reduced symptoms of PTSD, depression, and anxiety, with sustained treatment gains at three-month follow-up. Seven clients (n=7) participated in the study. Across all three outcomes (PTSD, depression, and anxiety), five of the seven (71%) participants did not meet a diagnosis for PTSD at three-month follow-up. Similar reductions were found at three-month follow-up for depression (71%) and anxiety, with four of the seven participants (57%) showing reduced symptoms of anxiety (Booysen and Kagee, 2021).

Concerns remain regarding ESTs for PTSD and therapy effectiveness in real-world clinical settings (observational rather than, for example, electronic records). Haven et al. (2021) proposed that disengagement limits the effectiveness of PTSD therapeutic interventions due to time limits. They investigated factors related to disengagement and treatment response in CPT including the written trauma account component (CPT-A)[21] using demographic characteristics and pre-treatment symptoms of PTSD and depression as predictors of disengagement and treatment response (Haven et al., 2021). The study included 42 women with PTSD from interpersonal trauma who were

[21] CPT-A includes the written trauma account component in CPT (Haven et al., 2021).

offered 12 individual weekly CPT-A sessions. Results indicated participants attended six or more treatment sessions, 13 individuals disengaged from treatment and 29 participants completed treatment. Of those who completed, 92% had reduced PTSD symptoms post treatment, and 46.2% had no reduction in symptoms post treatment (Haven et al., 2021). Reduced depressive symptoms and increased positive affect were related to treatment completion and increased session attendance. Older age was related to completing treatment, and pre-treatment PTSD symptoms were related to symptom reduction (Haven et al., 2021). The authors suggested explanations for the relationship between younger age and disengagement might be that younger age are busier with current life demands (Goodson et al., 2017), though this explanation was not substantiated in their study (Haven et al., 2021).

In order to determine the effectiveness of PTSD interventions in targeting emotion regulation difficulties, as well as the impact that emotion regulation difficulties may have on treatment disengagement from TFT, Shnaider et al. (2021) study examined the relationship between emotion regulation difficulties and treatment outcome among individuals receiving group CPT for PTSD. They aimed to determine whether emotion regulation difficulties improved over the course of treatment, as well as to examine the impact of pre-treatment emotion regulation difficulties on treatment effectiveness and disengagement. The study comprised 100 individuals who received CPT sessions delivered once per week over a 12-week period. Findings indicated significant improvement in PTSD symptom severity across treatment. Seventeen (17%) individuals disengaged from treatment. Disengagement was defined by the authors as missing at least the last three group treatment sessions (i.e., sessions 10, 11 and 12) (Shnaider et al., 2021).

(4) TFT for Intensity, Duration or Session Dose for PTSD and Disengagement

ESTs for PTSD have been identified as effective treatments for symptom reduction; both PE and CPT have received good outcomes in research studies, however, these treatments also experience significantly greater disengagement rates (i.e., 36%) relative to non-TFT (i.e., PCT, 18%) (Imel et al. 2013). Gutner et al. (2016) proposed

that to fully understand why individuals disengage from CBT for PTSD, it must be first understood when disengagement occurs during the treatment. Many factors influence disengagement, such as early versus late disengagement in the course of treatment and achieving significant symptom improvement so that additional treatment sessions are no longer needed. This possibility has been proposed in other research where participants receiving the 12-session PE protocol needed an average of six sessions to achieve a 50% reduction in PTSD symptoms from their pre-treatment PTSD symptom scores (van Minnen and Foa, 2006). Participants' avoidance behaviour may also account for disengagement early during CBT for PTSD, given the component on confronting the trauma memory in TFT (Gutner et al., 2016). In this study, participants with sexual assault PTSD (n=321) were randomly assigned to CPT, PE, or a minimal attention control condition (MA).[22] Findings indicated that most participants disengaged within the first half of the course of treatment. A large proportion of participants (16%) also disengaged prior to the first treatment session and before receiving any treatment, which Gutner et al. (2016) recognised as an important finding since different factors influence not starting a treatment relative to starting and then disengaging. Those who disengaged did so within the first half of the treatment course (by session five), and a smaller percentage of participants disengaged in the second half of treatment. Gutner et al. (2016) speculated that it was possible that those who disengaged had received a significant reduction in PTSD symptoms to warrant additional sessions unnecessary (Gutner et al., 2016). However, the authors were unable to examine PTSD symptom severity for those participants who disengaged from the treatment because they did not have their self-report data. Since this speculation is unsubstantiated in the study, it strongly suggests researcher bias.

Poor response to treatment and disengagement rates from TFT impact their effectiveness in PTSD symptom improvement (Hendricks et al., 2018). In this study, 73 participants with sexual assault PTSD received intensive PE (iPE) in 12 sessions over four days (intensive phase), followed by four weekly PE sessions (booster phase). Treatment outcomes for severity of PTSD symptoms were assessed at pre-

[22] Attention control groups are a design element used to reduce threats to internal validity in randomised controlled trials (RCT). An attention control group is an inactive substitute for the intervention (Aycock et al., 2018).

treatment, post-treatment and at three and six months. Results showed a pre- to post-treatment decrease in PTSD symptom severity, with 71% of participants responding to treatment that was sustained at three- and six-month follow-ups (Hendricks et al., 2018). None of the participants disengaged during the intensive phase and only 5% during the booster phase (Hendricks et al., 2018). The authors speculated that some PTSD clients may have difficulty overcoming avoidance behaviour as a possible explanation for these findings. The authors further speculated that standard weekly TFT may leave clients with more time to engage in avoidance behaviours between sessions, however, their study does not support these conclusions. Results demonstrated four paths to PTSD treatment response (responded to the treatment): fast responders (13%), slow responders (26%), partial responders (32%), and non-responders (29%). Living conditions and between-session fear habituation were found to predict outcome. Participants living alone were more likely to belong to the partial responders than to the non-responders' cluster, and participants showing more between-session fear habituation were more likely to belong to the fast responders than to the non-responders' cluster (Hendriks et al., 2018). The authors suggested that iPE was a safe and effective treatment for clients with PTSD presenting with multiple interpersonal trauma (Hendriks et al., 2018).

A study by VanWoudenberg et al. (2018) to determine the effectiveness of an intensive TFT for PTSD, 347 clients with PTSD (70% women) were given daily sessions of PE and EMDR over eight consecutive days (16 sessions in total), including physical activity and psychoeducation. Post-treatment results indicated 82.9% of participants showed a clinically meaningful result; 54.9% had reduced symptoms and disengagement was low at 2.3% (VaWoudenberg et al., 2018). The authors suggested that intensive TFT plans can be effective for clients with PTSD and are associated with low disengagement rates (VaWoudenberg et al., 2018).

Zepeda Méndez et al. (2018) investigated the potential benefits of a five-day treatment of EMDR with trauma-informed yoga[23] for PTSD. In this pilot study, 12 clients with a diagnosis of PTSD participated in the study and received two EMDR sessions and one trauma-informed yoga session per day. Nine of the12 clients

[23] Trauma-informed yoga: adapted from Trauma-sensitive yoga (Emerson and Hopper, 2011) and Yoga for the mind (Mason, 2011).

reported improvement corresponding to a reduction in PTSD symptoms, and there was no disengagement from the treatment, which the authors suggested is related to tolerability of the treatment (Zepeda Méndez et al., 2018). At two weeks follow-up, one client disengaged from the study; nine of the 11 clients reported a reliable change in self-reported PTSD symptom improvement, and two clients no longer met the criteria for a PTSD diagnosis (Zepeda Méndez et al., 2018). Results indicated that clients with more complex types of trauma and comorbid disorders benefitted from an intensive treatment programme (Zepeda Méndez et al., 2018). Further investigation of the effectiveness of intensive treatments for clients with PTSD who have not benefitted from regular ESTs was recommended, to compare intensive formats with regular weekly TFT sessions in determining the long-term effects (Zepeda Méndez et al., 2018).

EST such as CPT should demonstrate significant treatment changes, as well as sufficient engagement rates. However, rather than be seen as a negative outcome, disengagement from TFT might also be interpreted as responding early to treatment with successful outcomes. Recent studies indicated that some participants may not require the full 12 sessions of CPT to achieve good outcomes (Szafranski et al., 2017). Holmes et al. (2019) proposed that understanding patterns of dose response for clients engaged in CPT for PTSD may provide transparency regarding the appropriate dose of treatment needed. Thus, clients who remained in therapy until they achieved sufficient symptom improvement at quicker rates, disengaged early due to needing fewer sessions. Data showed 42% of clients did not complete treatment (n=188), with most disengaging between Sessions two and five. The average rate of change from pre-treatment to session five was, −4.20 (−.16), and for clients completing five to 12 sessions, −8.44 (−.31), a difference of (−.15), showing those clients who improved at a greater rate attended more sessions, not less (Holmes et al., 2019).

Youn et al. (2019) explored client predictors of treatment outcome and disengagement to identify predictors of treatment engagement in community settings. Treatment engagement included: number of weeks in the study, number of sessions with

repeated CPT content,[24] number of unique CPT sessions attended, frequency of session attendance and consistency of session attendance. Findings showed language to be a significant predictor of treatment engagement, and clients who reported higher quality of life at baseline measures were less likely to repeat CPT session content (Youn et al., 2019). Those with increased baseline barriers to treatment had a reduction in PTSD symptoms with improvement over time. In terms of treatment engagement, it was found that those clients who repeated more session content were more likely to complete treatment (Youn et al, 2019).

Predicting different types of client disengagement during stages of PTSD treatment may reduce numbers (Kline et al., 2020). Kline et al. (2020) stated that clients disengage from TFT for a number of reasons and establishing those clients most at risk of disengaging is difficult. In their comparison study to examine pre-treatment predictors of nonstarters, starters and client disengagement, 200 participants were randomised to a choice of PE or medication, or a 'no choice' and re-randomised to PE or medication, receiving up to 10 sessions of treatment. Overall, disengagement rates remained high (n=66; 33%), with a substantial minority being nonstarters (n=19; 28.8%). These differences remained even when comparing nonstarters to clients that began treatment but eventually disengaged. Kline et al. (2020) cited differences in participant beliefs (clients perceived credibility of the treatment) toward one treatment over the other was linked to early disengagement. Treatment-related beliefs (Westra, Constantino and Aviram, 2011) and clients' treatment choice have been linked to outcomes and disengagement across all disorders and associated approaches (Oldham et al., 2012).

(5) PTSD Treatment with non-TFT and Disengagement

Although TFT are considered the gold standard in the treatment of PTSD, they are limited by some clinical outcomes due to clients being unable to tolerate their exposure component, and consequently, disengagement rates are high (Foa and

[24] CPT content included material that the client can discuss and use with the clinician as the basis for assigning homework for the next session (Youn et al., 2019).

Meadows, 1997, p.449). Interpersonal therapy (IPT) does not include an exposure to traumatic memories component, but focuses on PTSD symptoms of interpersonal impairment, such as social isolation, difficulty in establishing trust in others and low self-esteem. Campanini et al. (2010) evaluated IPT in a group format, adapted to PTSD, as an adjunctive treatment for clients who failed to respond to medication treatment. Results indicated IPT was effective in decreasing symptoms of PTSD, and in decreasing symptoms of anxiety, depression, social adjustment and quality of life (mean decreased from 72.3 at baseline to 36.54 at endpoint). The treatment was well tolerated by clients and less disengagement was indicated (seven clients out of a total of 40 (17.5%)) (Campanini et al., 2010).

Silveira Júnior et al. (2011) investigated whether therapists' countertransference at the early stages of brief-PDT for clients with PTSD could predict client disengagement. A group of 131 trauma clients with PTSD (83% women) were evaluated. Clients' clinical and demographic characteristics, such as age, education, relationship status, PTSD diagnosis, and severity of diagnosis, were correlated with the therapists' countertransference feelings in the Assessment of Countertransference Scale (ACS), such as closeness, rejection, and sadness. Clients were followed-up during treatment to verify the association between initial countertransference and treatment outcome, defined as discharge and disengagement. Disengagement rate was high (34.4%). Findings indicated no association between initial countertransference and treatment outcome. Silveira Júnior et al. (2011) suggested further studies might assess changes in countertransference *during* treatment, and how such changes impact treatment outcomes.

In a pilot study, Kelly and Garland (2016) evaluated a trauma-informed model of mindfulness-based stress reduction (TI-MBSR) as a phase 1 PTSD treatment for female survivors of interpersonal violence (IPV). In a community-based setting, 23 women with a history of IPV were randomly assigned to an eight-week TI-MBSR intervention or a waitlist (WL) control group. Symptoms of PTSD, depression and anxious and avoidant attachment were assessed at pre- and post-treatment. Of the participants, 53% (n=10) completed all eight sessions, 26% (n=5) completed seven sessions, 11% (n=2) completed six sessions, and 5% (n=1) completed five sessions (Kelly and Garland, 2016). One participant attended only the first session and did not

return. Participants in the TI-MBSR group were associated with reduced PTSD and depressive symptoms (PTSD treatment group pre-treatment average was 49, and post treatment, 35, compared to the WL group PTSD pre-treatment average of 46, and post treatment, 40). In the depressive symptoms treatment group, pre-treatment average was 24, and post treatment, 11, compared to the WL group depressive symptoms pre-treatment average of 22, and post treatment, 17 (Kelly and Garland, 2016).

Results also indicated significant reductions in anxious attachment symptom scores, but reduction was not found to be significant in avoidant attachment scores (anxious attachment treatment group pre-treatment average was 3.7, and post treatment, 3.2, compared to the WL group anxious attachment pre-treatment average of 2.8, and post treatment, 3.1. Avoidant attachment treatment group pre-treatment average was 3.9, and post treatment, 3.8, compared to the WL group avoidant attachment pre-treatment average of 3.5, and post treatment, 3.4) (Kelly and Garland, 2016). Participants' self-reported mindfulness skills were practiced for an average of 190.5 minutes per week. Results indicated that more minutes of mindfulness practice per week significantly predicted reduced PTSD symptom change with significant reduction for PTSD symptoms in the TI-MBSR group ($p = .008$), compared to no significant reduction in the WL group, ($p = .25$): 80% and 40% reduction, respectively (Kelly and Garland, 2016). The authors concluded that minutes of mindfulness practice per week significantly reduced PTSD symptoms and TI-MBSR was a feasible phase 1 intervention (Kelly and Garland, 2016).

Müller-Engelmann et al. (2017) pilot study examined the feasibility of mindfulness-based stress reduction (MBSR) as a standalone intervention in clients with PTSD and with variable trauma types. Fourteen clients participated in eight weeks of MBSR. MBSR included practical exercises which consisted of a body scan (attention is directed systematically and step by step through various areas of the body), yoga (Hatha yoga involves performing movements with present-moment attention) and sitting and walking meditation (Müller-Engelmann et al., 2017). The sitting meditation began with short sitting periods that were increased incrementally to 30-minute meditations, focusing on breathing. Clients were assessed pre- and post-treatment and at one-month follow-up, to determine the effects of the intervention. On completion of treatment, clients were interviewed regarding their experiences with

MBSR for feedback. Nine clients completed the treatment (Müller-Engelmann et al., 2017). Six of the nine clients who completed the treatment no longer fully met the criteria for PTSD diagnosis (42.9% of the original sample) confirming efficacy of MBSR in reducing PTSD symptoms. After an average of 2.6 sessions, 35.71% disengaged (Müller-Engelmann et al., 2017). The nine clients who completed the treatment participated in more than 50% of the sessions, attended an average of 6.89 sessions and had practiced the learned techniques an average of 5.06 times per week (Müller-Engelmann et al., 2017). Clients' interviews reported augmentation of wellbeing and improvement regarding the handling of difficult situations and more distance from the traumatic event. The authors suggested that post-treatment interviews could be better adapted to the needs of PTSD clients to address the high disengagement rates, for example, giving clients more information regarding the exercises and including shorter exercises to manage acute distress (Müller-Engelmann et al., 2017).

Proença et al. (2019) investigated if IPT for sexual assault PTSD had similar reduction of PTSD symptoms, and lower disengagement rates as PE, the gold standard, and the most research studied exposure therapy for PTSD (Foe and Meadows, 1997, p.449). This was the first formal study in the literature review using a non-TFT approach IPT for sexual assault PTSD. However, Proença et al. (2019) found disengagement rates similar to research applying PE, as around 30% of clients disengaged from IPT treatment. The authors suggested it is clinically recognised that different therapists, despite similar training, have different capabilities showing different client outcomes. It is possible, therefore that the performance of one therapist could partially explain the high disengagement rate. One therapist treated 60% of women who started and disengaged from IPT and only one of her four clients completed treatment. Other therapists had at least a 75% completion rate. No other explanation for the high disengagement rate was found (Proença et al., 2019).

Limitations and External Validity

Limitations

Two significant limitations to this review are the lack of literature evidencing TFT and non-TFT approaches differentiating 'types' of PTSD, and disengagement. Also, lack of research for non-TFT approaches for PTSD generally, and specifically, for sexual assault PTSD. Due to the paucity of literature specifically focused on PTSD and sexual assault, it was necessary to explore broader content to gain perspectives regarding what can be understood from studies in the general context of PTSD and its treatment approaches, and in so doing develop a depth of appreciation of what is already known about psychotherapy models for PTSD. Whilst accepting that some of the research included in the review does not attend to PTSD from sexual assault, the generalist PTSD material offers the opportunity to gain a rich depth of understanding regarding the complexity of the broader field within recommended models for the treatment of PTSD, which in turn offers insight that might be cogent to the theoretical framework and the lens through which this research is viewed. Sexual assault PTSD may evolve its own distinctive nuance from the PTSD foundation already established, just as the concept of PTSD emerged from the study of many forms of violent trauma and sexual assault; understanding this broader literature is relevant and thus formed part of the literature review.

This review has identified the scope of works that are currently available in the research area of disengagement from PTSD treatments. The lack of research may be twofold; firstly, ESTs are relatively recent treatment developments for PTSD, and contemporary treatments or evolving research difficulties within treatments might need to be built upon. Secondly, this research question may be too narrow, for example the development of PTSD treatments for differing trauma types might need time to develop within the research field of PTSD. This literature review was based on high-quality studies from within the field of treatments for PTSD, nevertheless, the conflicting results from comparative research studies, the predominance of TFT for symptom improvement and/or disengagement and consistently reported evidence-based, empirically supported PTSD treatments, and the discernible absence of non-TFT approaches for PTSD in the review, are worrying.

Of the articles included in this literature review, 21 (60%) of a total of 35 articles were control trials (CTs) or randomised control trials (RCTs), the majority of which were from recommended ESTs using quantitative methods and statistical measures. Lack of qualitative research literature for PTSD and sexual assault PTSD and disengagement is evident from the entire review of the literature. The next section ascertains possible explanations for this in a closer examination of the medical model, classification, and diagnosis.

The Medical Model: Classification and Diagnosis

The concept of PTSD evolved from studying many forms of violent trauma, and sexual assault is a small subset. Historically, the United States Department of Veterans Affairs (then known as the Veterans Administration, or VA) developed a way to diagnose and treat returning service members presenting with a wide range of mental health difficulties after the Second World War (Wilson, 1993). In 1952, the American Psychiatric Association (APA) published the first Diagnostic and Statistical Manual of Mental Disorders (DSM),[25] a classification system developed by the armed forces during the war (Wilson, 1993). Despite numerous criticisms (for example, the first DSM, published in 1952, included 108 categories of mental disorders, and by 2013, the latest iteration of the DSM (DSM-5) included 354 categories of mental disorders) the DSM is considered the most important record for the diagnosis and classification of mental disorders (Khoury, Langer and Pagnini, 2014).

An increasing tendency in the medical model approach to *medicalise* patterns of behaviour and mood in which medication is not considered necessary, has both professional and ethical implications (Shedler, 2010). For example, evidence of EST of the effectiveness of psychotherapy for mental health disorders such as anxiety and depression are well recognised (APA, 2013). Research studies have shown that psychotherapy as a stand-alone approach for these mental health disorders is often superior to medication (Shedler, 2010). Nevertheless, medication has been found to be

[25] https://psychiatry.org/psychiatrists/practice/dsm

the most common treatment approach used by psychiatrists, whilst disregarding the possibility of psychotherapy for patients, calling into question both ethical and professional practice (Migone, 2017).

Additionally, scientific research of the benefits of a specific type of medication for a specific psychiatric diagnosis remains unclear (Khoury, Langer, and Pagnini, 2014). Yet medications such as antidepressants and psychotropics[26] are often prescribed for a variety of mental health disorders, including sleeping, anxiety, depression, irritability, eccentricity, temper tantrums in youth, and crankiness of old age (Frances, 2013, p.105). The pharmaceutical industry's unhealthy influence on the revision process of the DSM is an often-cited criticism of the APA who are committed to the medical model. For example, pharmaceutical companies finance most (if not all) RCTs for efficacy of medications. Consequently, decisions of which studies are approved will be biased towards pharmaceutical companies' vested interest (Migone, 2017). Psychotropic prescribing by psychiatrists finances a large part of the DSM linked to research activities, which also finances the APA, leading to questions regarding the clinical necessity of such research and ethical considerations of pharmaceutical over-investment in the treatment of mental illness (Laungani, 2002; Frances, 2013, Greenberg, 2013).

Issues of validity proliferate classification and diagnosis of mental health disorders in the DSM and the ICD, since diagnostic approaches by the psychiatrists and clinicians using them are different, leading to less agreement in diagnosis, and possibly less reliability (Tyrer, 2014). Additionally, difficulty of inter-rater reliability across the DSM and ICD for diagnoses (e.g., different diagnostic tools used) may affect external reliability and consistency over time, place, and individual; for example, the same diagnosis will be arrived at irrespective of hospital, country, and individual (Tyrer, 2014). The danger of unstable reliability is a tendency to create *more* diagnoses rather than fewer, and to create pathology out of 'normal' variations. Discernment regarding

[26] Psychotropic drugs (or psychotropics) in clinical contexts relates to any drug that has significant effects on psychological processes, such as thinking, perception, and emotion. Therapeutic agents designed to ameliorate a mental condition include antidepressants, mood stabilisers, sedatives, and antipsychotics.
https://dictionary.apa.org/psychoactive-drug

the identification of pathology needs an overview, which, in the DSM system, is lacking (Tyrer, 2014).

Other criticisms of the DSM are that it leans towards an oversimplification of human behaviour, reducing it to labels and numbers that risks losing sight of individuals' unique humanness (Khoury, Langer and Pagnini, 2014). Possible risks include misdiagnosis or even over-diagnosis, in which groups of people are labelled as having a disorder because their behaviour does not fit with some *ideal*, and as a way of pathologising[27] people whose behaviour we do not like or cannot explain, that is measured against an ideology of an objective unmeasurable ideal.[28]

If mental health can attract investment because of possible incentives derived by pharmaceutical companies, there is less interest in investing in psychotherapeutic research where medication is not required. Non-TFT approaches underpinned by holistic and complementary interpersonal therapies that focus on individuals' wellbeing, does not produce a profit to private companies, on the contrary, mental health is profitable because it increases use of medications in research for treatments (Migone, 2017). This, in part, explains the paucity of non-TFT approaches for PTSD in the literature review for this study. The next section examines the medical model further, in probing its continued primary treatment approach in the literature review, focusing on classification and diagnosis of mental health, and the formidable alliance of medicine and science.

Empirically Supported Treatments (EST), and Evidence-Based Practice (EBP)

The validation of treatments with proven effectiveness has obtained credibility due in part, to empirically supported treatments (EST), and evidence-based practice (EBP) in psychological treatment approaches. EST are those treatments that have been studied

[27] Pathology/pathologising refers to the scientific study of functional and structural changes involved in physical and mental disorders and diseases. https://dictionary.apa.org/pathology
[28] Selective *s*erotonin *r*euptake *i*nhibitor (SSRI) is any of a class of antidepressants that are thought to act by blocking the re-uptake of serotonin into serotonin-containing presynaptic neurons in the central nervous system (APA Dictionary of Psychology, 2020).

in clinical trials or randomised control trials (RCT), that have demonstrated effectiveness in specific disorders such as anxiety (Castelnuovo, 2010). RCTs in research measure the effectiveness of a treatment (Hariton and Locascio, 2018). EBP relies on evidence from RCTs in psychology as guiding quality, regulation, and standards of psychotherapy practice for recommended psychological treatments (Berg, 2019).

There are several contentious issues related to the external validity of recommended, empirically supported psychotherapies (ESTs) that should be considered. Firstly, the design requirements of RCTs do not allow for *measures* of understanding the multifaceted nature of many mental health difficulties around complexity of individual differences, interpersonal processes, and the scope of potential outcomes intrinsic to psychotherapy practice. Treatment manuals such as the DSM-5, have standardised protocols or define the practice of psychotherapy from either a quantitative research-based behavioural model or symptom-focused medical model (Erskine, 1998). The therapeutic relationship is not considered central to medical model approaches in such practice manuals (Erskine, 1998).

Secondly, ESTs are often characterised by unacknowledged sampling issues, methodological constraints, researcher bias, and limited outcome criteria in research (Berg, 2019). For example, patient selection is based on symptoms determined by the DSM-5 commonly used in RCT studies, because the treatment groups and control groups[29] formulate and clarify results. However, this restricts the population studied to only a small proportion of individuals who seek psychotherapy services, since very many clients seek psychotherapy for issues beyond those symptoms specified in diagnostic manuals (Shean, 2014). Furthermore, RCT presume that all patients receiving a particular therapy model, experience the same treatment and are guided in the same way, yet psychotherapy in practice is extremely difficult to standardise so that its procedures and techniques are used in the same way by all therapists, irrespective of training, experience, and personality. The unique relationship between

[29] Control group is a comparison group in a study whose members receive either no intervention at all or some established intervention. The responses of those in the control group are compared with the responses of participants in one or more experimental groups that are given the new treatment being evaluated.
https://dictionary.apa.org/control-group

the client and therapist will engender qualities and features, with the potential of producing that which cannot be predicted entirely by diagnostic classification and standardisation within treatment approaches (Castelnuovo, 2010).

Randomised Controlled Trials (RCTs)

The difficulty of validity of RCTs in psychological interventions as compared to, for example, medication, is that outcomes of the effects of the latter are unlikely to vary across individuals and have a straightforward cause and effect relationship that is biological or chemical. In contrast, psychological interventions tend to interact with other factors, such as personality (Clay, 2010). Therefore, some of the assumptions of using RCT studies in psychological interventions must be questioned. For example, the assumption that most patients can be treated for a single disorder and that disorders can be treated independently of personality factors is misleading. In fact, comorbidities[30] are much more common presentations in mental health disorders, and inextricably linked to personality factors, such as resistance to change, or vulnerable to relapse, making outcomes limiting, and long-term effectiveness for psychological interventions very challenging (Westen, Novotny and Thompson-Brenner, 2004).

Additionally, the use of RCTs to study the effectiveness of psychotherapies generates ethical concerns around possible risks for individuals in receiving the experimental treatment (the control group) rather than the treatment itself, and the lack of data outcomes justifying a clinical trial rather than a direct treatment (Stines and Feeny, 2008). Ethical doubts about psychotherapeutic treatments that have shown some effectiveness in RCTs may also impact clinicians' choice of treatment when assessing patients and may result in the under-utilisation of some treatments (Fairhurst and Dowrick, 1996).

EST and the sole reliance on research outcomes from RCTs for validity of effectiveness of psychotherapy treatment, limits the options that can be drawn from a

[30] comorbidity is the simultaneous presence in an individual of more than one illness, disease, or disorder.
https://dictionary.apa.org/#

very broad and diverse choice of evidence. There are other sources, including qualitative data and accounts from the field from clinicians using an intervention, for example. Qualitative research methodologies such as Interpretative Phenomenological Analysis (IPA) may provide a useful method for the evaluation of the effectiveness of idiographic approaches to psychotherapy, where outcome is not understood solely in terms of effective symptom reduction but rather focuses on the uniqueness of individuals' lived experiences within the world, as opposed to generalised outcomes inherent in quantitative methods (Shean, 2014). (Quantitative and qualitative research methods and IPA are reviewed in detail in the Methodology Chapter 3).

Two studies included in the review utilised qualitative methodology: Frye and Spates' (2012) comparative study of TFT PE with MBSR and Emotion Regulation, and Paintain and Cassidy's (2018) comparative study of TFT-CBT with psychodynamic approaches for PTSD. One study, by Müller-Engelmann et al. (2017), incorporated a mixed-methods approach, combining quantitative and qualitative data collection and analysis in their study of non-TFT MBSR as a standalone therapy treatment for PTSD.

This review also included two case study reports: Frye and Spates (2012), and Booysen and Kagee (2021). The first compared TFT PE to Mindfulness and Emotion Regulation, as a treatment for PTSD, and Booysen and Kagee's (2021) case study explored the effectiveness of brief PE for PTSD. Both studies were concerned with reducing the trauma narrative content in TFT that some clients are unable to tolerate, in order to improve treatment completion and reduce disengagement rates. Booysen and Kagee (2021) were concerned with access to treatments and dropout in low resource settings. Lack of qualitative reports yielded for this review might be linked to attitudes within the research field towards generalisibility and transferability in research outcomes; the view that one person or a small group cannot represent all similar groups or populations in a valid and rigorous way, as quantitative methodology claims. Historically, quantitative methods have dominated the field of research, hence assumptions are formed that the criteria for validity are quantitative, as reflected in the small yield of qualitative research reports included in this literature review (Yardley, 2016). It should be noted, however, that qualitative methods adhere to many of the same principles of scientific rigour as quantitative methods (Palinkas,

2014). Interview data may be of little significance when analysing the outcomes of RCT, however, qualitative methods enable an investigator to realise a deeper understanding of the process and context of an RCT; for example, the interpretation of unexplained findings from analysis of quantitative data (Palinkas, 2014).

Four reports included in this research review use non-TFT approaches: Silveira Júnior et al. (2011) and Paintain and Cassidy (2018) research PTSD utilising the psychodynamic model, and Imel et al. (2013) and Belsher et al. (2019) utilise the PCT model.

The next section examines non-TFT approaches, exploring possible explanations for models' under-utilisation within research for treating PTSD and sexual assault PTSD.

Psychodynamic Psychotherapy (PDT)

A number of criticisms are aimed at the psychodynamic model, however four often cited criticisms are outlined in this section. The first criticism aimed at the PDT approach is that it is deterministic, suggesting that one's behaviour is predetermined with little control over the direction of one's life. In essence, however, psychic determinism might be interpreted as being 'without awareness', while insight and emotional resilience are analogous to 'awareness' and autonomy in one's life (Fulmer, 2018). Principally, the central aim of psychodynamic therapy is both cognitive and emotional awareness (Fulmer, 2018).

The second limitation and criticism of the psychodynamic approach is its over-emphasis on childhood experience as the source of mental health disorders. In PDT theory, personality begins forming early as infants begin to interact with environmental factors that will shape character. Personality is heavily influenced by caregivers; the amount of attunement and functionality in one's early environment will shape one's personality. John Bowlby (1907-1990) evolutionary theory of attachment suggests that children come into the world biologically pre-programmed to form attachments with others, because it is vital for survival. A child has an innate (i.e., inborn) need to attach to one main attachment figure (Holmes, 2014). Thus,

depending on the environment, personality develops differently (Fulmer, 2018). It is reasonable to suggest that functional environments lead to healthy personality structures, while dysfunctional environments are associated with disordered personality structures (Fulmer, 2018).

Thirdly, influence of therapist effects on therapy outcomes is a valid criticism of the PDT model, though it is reasonable to suggest that all therapists in all therapeutic approaches can potentially impact therapeutic outcomes, and since therapists are active participants in the therapy encounter; their projections towards clients are relevant (Oelsner, 2013) (therapist effect is considered at length in the discussion of the person-centred model, later in this chapter). Therapists' countertransference runs the risk of undermining the therapeutic sessions. However, therapists who are self-aware and regularly monitor their own internal state, will recognise clients' transference processes and may choose to address and process them with the client (Fulmer, 2018). The DSM does not consider the wide degree of therapist and inter-treatment variability within a given model or treatment. Even when a manual is closely followed for EST approaches, such as CBT, therapist effects are significant (Malik et al., 2003).

A final criticism of the PDT model is lack of evidence to demonstrate its efficacy (Yakeley, 2014). It has been shown in this literature review that the field of research and practice in psychotherapy treatment approaches for PTSD has been deeply influenced by the rise of the EST movement (Castelnuovo, 2010). In 1998, a list of ESTs became well-established within the mental health field, with efficacious criteria for treatments supporting the cognitive and behavioural therapies for the treatment of PTSD that now dominate research for trauma (Castelnuovo, 2010). Shedler (2010) stated the perception that PDT approaches lack empirical support does not lend itself to available scientific evidence and may reflect selective dissemination of research findings supporting the cognitive and behavioural therapies for the treatment of PTSD, despite evidence of efficacy demonstrating equal effectiveness of PDT in the treatment of a range of mental health disorders (Shedler, 2010).

Very few RCTs have included PDT treatments for PTSD compared with those that have been carried out for TFT such as CBT, leading to a lack of available evidence

supporting PDT, and prompting questions regarding the selection of CBT over PDT approaches for the treatment of PTSD (Schottenbauer et al., 2008).

Person-Centred Therapy (PCT)

The three core conditions in PCT: unconditional positive regard, empathy, and congruence, present a considerable challenge to the person-centred therapist. In Rogers' theory of PCT, there is no model or therapeutic strategies or skills to be acquired, but rather, emphasis is placed on the personal attitudes or attributes 'experienced' by the therapist, and how they are communicated to the client for successful therapy outcomes. The notion of a non-directive therapist stance in PCT has been widely criticised, however. Kahn (1999) argues that it renders a therapist passive in the face of clients' presentations and denies the inevitable impact of the therapists' own thoughts and feelings on the therapy process itself. Rogers' theory rejects the therapist' interpretations and transference process, which he believed is caused by therapists' agenda or the therapist taking an evaluative stance towards the client. PCT therapists could avoid transference phenomena by remaining congruent and taking a non-authoritarian stance (Meador and Rogers, 1979).

Although Rogers believed that symptoms arose from past experiences, he asserted that it was more useful for the client to focus on the present and future rather than on the past (Meador and Rogers, 1979). In trauma informed PCT for example, orientating to the 'here and now' emphasised a separation from the traumatic event, which can take place within the safety of the therapists' stance. Rather than just liberating clients from their past, as in the PDT approach, PCT therapists aim to encourage clients to think about the present to promote personal growth and wellbeing. However, transference, in its most general form, is an intra-psychic organising of clients' experiences from what the client has learned from her past, and in understanding what to expect from the world in the present (Kahn, 1999). Awareness of the client's past can inform her present and can be a powerful driver for change in therapy. Emphasis on the client's subjectivity in PCT describes rather than conceptualises therapeutic change. Non-theoretical parameters, such as the spontaneity of self-actualising, are descriptions based on theorist ideals, rather than

grounded in a developmental, contextual framework for practice and research (Kahn, 1999). Reliance on the subjective experiences of individuals in PCT also makes it difficult to objectively measure effectiveness (changes that occur in therapy) in research studies, and challenges comparison of one set of qualitative data with another (Gibbard and Hanley, 2008).

The non-directive therapist in PCT allows the client to generate their own solutions to their problems. However, individual differences and clients presenting with moderate to severe distress may feel a need for some direction for change to take place and reduce symptoms. Victims of sexual assault PTSD, for example, often continue to dissociate in the face of perceived threats long after the assault experience and suffer from profound feelings of helplessness, having difficulty planning effective action (van der Kolk, 2000). The past continues to intrude in the present for women with sexual assault PTSD, where maintaining and sustaining interpersonal relatedness in the therapeutic relationship is continually challenged and disrupted, with possible development of withdrawal ruptures that require therapist intervention.

Research outcomes for lasting change in PCT, when therapists carefully followed guidelines, omitting any therapist directive or skills teaching, found it did not lead to lasting change for clients (Gibbard and Hanley, 2008). Further criticisms argue that it is not possible to completely avoid therapist bias or direction. Everyone, as a result of their unique life experiences, has some degree of bias, even when trying to remain completely objective. The qualities of the therapeutic relationship in PCT (unconditional positive regard, congruence, and empathy) that are necessary, are not found to be sufficient for bringing about change in clients with more complex or severe mental health disorders (Hewitt and Coffey, 2005).

This, coupled with a lack of evidence-based practice (EBP) for the key theories underpinning PCT generally, make it a vulnerable approach, much like PDT, in a political climate where it has become increasingly obvious that pursuing quantitative outcome research to meet the demands of government, and professional panels (such as The Health and Social Care Committee's Expert Panel in the area of mental health services in England) insisting on restrictive forms of evidence-based empirically supported treatment in therapy, has become an imperative (Roth and Fonagy, 2004).

Twelves reports included in this review investigated sexual assault PTSD and disengagement, ten of which were RCTs and two were non-trials. The first, Frye and Spates' (2012) non-trial report, was a comparative study of TFT with non-TFT and disengagement. The authors applied the non-TFT of mindfulness and emotion regulation skills with PE treatment in a single case study, to augment a client's stabilisation throughout the exposure phase of PE to reduce their attempts to withdraw, avoid, or disengage from the treatment. Reduced PTSD symptoms and treatment completion were evidenced that equalled the outcomes of TFT alone. The second non-trial report in Haven et al.'s (2021) study, investigated those factors related to disengagement and treatment response in TFT CPT-A,[31] with demographic characteristics and pre-treatment symptoms of PTSD as predictors of disengagement and treatment response. The summary of findings indicated increased positive affect was related to treatment completion and increased session attendance.

The key limitation of this literature review is both the paucity of qualitative research to draw on from non-TFT approaches within current research, and with findings for effective PTSD treatments across different trauma types, such as sexual assault PTSD. A review that yielded more qualitative research studies might have brought together research that focused on sexual assault PTSD and treatment disengagement, in order to attempt to illuminate the research questions posed in this study.

Summary of Findings

The aim of this literature review was to examine those influences that compel women in sexual assault PTSD therapy to disengage before completing their treatment. A review using PRISMA guidelines (Page et al., 2021), identified 35 articles as meeting the inclusion criteria.

The evidence for TFT approaches for PTSD and sexual assault PTSD and disengagement remain high. Due to the paucity of research for PTSD treatment

[31] CPT-A includes the written account component of CPT (Haven et al., 2021).

generally, not specifically for trauma types (which were fewer), more than half of the reports in this literature review are TFT approaches with outcomes that include populations from mixed trauma-types, and with some studies (eight in total), including depression either as a trauma symptom, or as a separate disorder that is measured alongside trauma symptoms. This merging of disorders or cross-classification diagnoses raises concerns about the reliability, validity, and especially heterogeneity (the quality of having very different characteristics or values) within diagnostic categories of contemporary classification systems, such as the DSM-5, and the limitations inherent in this system to provide more relevant diagnoses and effective treatments. Research to reduce disengagement rates examined client predictors and characteristics to predict outcomes and disengagement rates, though few consistent predictors were found, and reduced disengagement rates were not significant.

The evidence for other forms of non-TFT (e.g., psychodynamic) is sparse and lacking in controlled studies and RCTs in the review. The most rigorous reviews of the PTSD psychotherapy literature state that the evidence is insufficient to recommend psychodynamic psychotherapy for PTSD (Youngner, 2013). Other non-TFT approaches that have been utilised for PTSD in this review are acceptance and commitment therapy (ACT), and skills training in affective and interpersonal regulation (STAIR). However, despite their rationale and efficacy, they require more evidence to recommend their use for treatment of PTSD (Youngner, 2013).

Some reports are included in the research literature, that reference therapist effects. For example, Van Minnen, Hendriks and Olff (2010), Ehlers et al. (2013) and Proença et al. (2019), refer to therapists' training, skill and experience and their impact on outcomes. Van Minnen, Hendriks and Olff's (2010) examination of the under-utilisation of TFT by therapists was found to be due to concerns of symptom worsening or disengagement, and/or a lack of training and confidence in the use of TFT. Ehlers et al.'s (2013) report examined Cognitive Therapy (CT) for PTSD in an NHS outpatient service. Although no therapist effects were significant, there was a trend for inexperienced therapists to achieve fewer good outcomes than experienced therapists, and with those therapists with less training choosing a non-TFT for PTSD. Proença et al. (2019) investigated non-TFT IPT for PTSD, to examine whether

outcomes were similar to TFT PE, to treat PTSD. Findings indicated similar disengagement rates for IPT equal to PE for PTSD. The authors suggested that despite similar training, therapists have different capabilities, reflecting different client outcomes. Hence, it is possible for the performance of one therapist to produce higher disengagement rates when compared to other therapists (discussion of therapist effects and disengagement from therapy is evaluated in the summary of this chapter, and further reviewed in the discussion, Chapter 4). Utilisation of TFT treatments and outcomes by therapists is another under-researched area within the field of PTSD treatment and disengagement.

The positive outcomes of PTSD symptom reduction evidenced from those recommended TFT in RCTs may not be observed or generalised to trauma research in clinical practice. For example, two reports: Hendricks et al., (2018) and Butollo et al., (2014), investigated whether similar outcomes could be achieved in clinical practice (in an outpatient setting). Both study outcomes produced effective symptom reduction and reduced disengagement rates, as evidenced in Hendricks et al. (2018) TFT intensive PE (iPE) (12 sessions over four days), and Buttollo et al. (2014) DET treatment with non-TFT gestalt-based framework. However, Ehlers et al.'s (2013) investigation of clients presenting in an outpatient clinic with a range of PTSD types, found improved symptoms in a standard eight-session CT treatment, but outcomes for disengagement were high (13.9%; 46 of 330 clients). Similarly, Holmes et al. (2019) found 58% of clients completed all 12 sessions of CPT; 42% of clients did not complete the treatment, with the highest disengagement between sessions two and five (n=188; overall 42% of clients disengaged; 26% disengaged by session five). Those clients who remained in therapy and completed the treatment achieved sufficient PTSD symptom improvement (Holmes et al., 2019). Perhaps this points to evidence of an anomaly in the length of time clients can tolerate TFT that has some bearing on disengagement rates.

The most encouraging findings are research that utilises non-TFT as an adjunct to TFT, where evidence of symptom improvement and disengagement rates are improved. Though findings are mixed, in the main, research suggests that the exposure component in TFT results in high rates of disengagement due to PTSD symptoms of avoiding of re-experiencing the trauma. Non-TFT such as MBSR used

as an adjunct with TFT (Frye and Spates, 2012), or as a stand-alone treatment (Campanini et al., 2010), and studies utilising Interpersonal Therapy (IPT) (Proenca et al., 2019), stand out as effective treatment options for PTSD, showing positive outcomes for both reduced symptoms and disengagement rates.

The present review has demonstrated that non-TFT IPT's effectiveness for PTSD as an alternative approach to TFT, due to its focus on improving interpersonal functioning, is very promising. Interpersonal skills, such as enabling a person to carry on effective interactions and relationships with others, or the ability to communicate one's thoughts and feelings to another, are abilities that are linked to reconnection with others and the world. For sexual assault PTSD, this approach is an important aspect of clients learning to engage within the therapeutic relationship. Preliminary findings from the literature review suggest positive outcomes for IPT in alleviating PTSD symptoms and reducing disengagement rates, and are equally effective for TFT PE, which was the most investigated exposure-based treatment research in the literature review.

Psychotherapy is a complex interpersonal and dynamic process rendering its study and effects methodologically challenging. Psychotherapeutic success and change is a multi-factor phenomenon and difficult to conceptualise, especially when the factors are not quantifiable, measurable, conscious, behavioural, or directly related to symptom relief (Binder et al., 2010; Hill et al., 2013). RCTs and meta-analyses have offered a rich account of generalisable outcomes for psychotherapy change and success. However, it must be acknowledged that they have significant limitations (Dragioti et al., 2017; Wampold et al., 2011), especially in considering external validity and how the findings apply to psychotherapy approaches in practice (Midgley et al., 2014).

Historically, the reports included in this review continue a long-standing tradition of a focus on the client to predict and determine reasons for disengagement from PTSD therapy. A review of the literature has illuminated two core factors when examining sexual-assault type PTSD and disengagement. The first is a preoccupation in research to develop a model of therapy for PTSD, honing and refining clusters of symptoms for a 'diagnosis'; drawn from broad inferences for generalisability: the majority of

reports included in this review incorporate mixed trauma type studies. Moreover, and directly related to the first, is concern that this trend in research will continue along the same trajectory. Political and contentious constraints of funding and 'investors' within mental health research, where an agenda, in the guise of promoting improvements in mental health treatments, limits the breadth and scope of research for PTSD around important aspects such as individual differences, differential trauma-types, non-TFT models, and the impact of manual-based therapy treatments that decentralise the therapeutic relationship. Conflicting issues around what is being measured in research for PTSD is confounding and difficult to demarcate. Evident from this literature review, reports for TFT for PTSD emphasise reduction of symptoms as a measure for improved outcomes, but recovery from sexual-assault type PTSD is not solely measured by reduced symptoms, or by achieving specific outcomes (therapy models for different types of PTSD presentation is discussed in detail in the Conclusion Chapter 6).

The second factor worthy of noting from a review of the literature is that the models developed for TFTs are all western-based. Applicability to non-western populations is debateable and of concern. It relies on a hubris of collusion where western-based notions embedded in contemporary research literature make assumptions that, 1) all PTSD presentations can be treated with a TFT model, and 2) that all populations can be offered the same treatment, irrespective of influence of race, culture, socialisation, and individual perceptions of mental health treatments.

Conclusion

It was found that research studies covered in the literature review addressed disengagement from sexual assault PTSD therapy by way of medical model TFT approaches. Client pathology, predictive methods, statistical measures, and a wealth of data on client demographics and characteristics, were emphasised in the review. Paucity of qualitative research studies, and possible reasons for this, indicate the necessity for future research investigations that encapsulate therapeutic models to promote clients' wellbeing and quality of life, to begin to understand why some clients choose to disengage from sexual assault PTSD therapy. This study presented

an opportunity to fill the knowledge gap regarding what influences clients to disengage from PTSD therapy, and more specifically, an opportunity to ask women directly about their experience of therapy for sexual assault PTSD.

Chapter Three

Methodology, Methods, and Analysis Procedures

Chapter Overview

The purpose of this chapter is to provide justification for the methodology chosen that underpins this study, as the most suitable to address the research question: What influences women with sexual assault PTSD to disengage from therapy? The chapter is divided into nine sections. The first is a discussion of the philosophical underpinning of the research paradigm Phenomenology and Interpretive Phenomenological Analysis (IPA) methodology, as the most suitable approach for this qualitative research study. In addition, how reflexivity and bracketing serve as essential components of the methodological framework are outlined, and the limitations of the research paradigm discussed. The second section describes the methods of data collection, and the third outlines the ethical conduct of the research procedures. This section identifies a semi-structured interview approach for four participants as the most suitable method for collecting qualitative data, and as a means of exploring the thoughts, feelings, and meanings of participants' accounts more deeply. The final sections conclude with full details of IPA analysis procedures and the themes garnered, including verification of analysis and observations about transferability and conclusion for the chapter.

Philosophical Approach

The importance of theory and methodology in research and the ways in which they are applied in the study will be evident to a large degree from the choices the researcher has made. It is important because the theory chosen often arises out of a 'value' position the researcher adopts that informs those research choices (Scie.org.uk,

2012). Choice of research question, selection of methodology, analysis of data, presentation and reporting of results are inseparable from and intrinsic to the researcher's psychodynamic lens and psychodynamic theory through which the thesis is reflected. The relationship between researcher and participant, the extent of the collaborative alliance, their histories, and values, are informed entirely from the researcher's psychodynamic psychotherapy perspective as referred to in Chapter 1. The next section discusses the philosophical approach to the research study, beginning with an overview of the qualitative research paradigm.

Qualitative research is the means by which researchers seek to understand both the context and the setting of their participants (Creswell and Creswell, 2018, p. 204). As a researcher, I gather information and interpret what I find. My interpretations are shaped by my own experiences, background, prior education, and training. Qualitative research is an approach for exploring and understanding the meaning individuals attribute to a particular phenomenon: the goal of the researcher is to make sense of and interpret the participants' meaning;[32] drawing general conclusions from a set of observations and widening specific observations out into broader generalisations (Creswell and Creswell, 2018, p. 63). An inductive style was important for this thesis, as the research aims to explore in detail how participants make sense of their personal and social world, and the meanings they hold.

A qualitative research approach was chosen because the intention of this research study was to explain phenomenology by relying on understanding the meaning individuals or groups give to a social or human problem (Creswell and Creswell, 2018). A quantitative approach would have been appropriate if a researcher was seeking to understand relationships between that which can be measured using statistical procedures. Since the goal of this study, however, was to examine the experiences and meaning making of individuals disengaging from PTSD therapy, a qualitative approach was considered an appropriate paradigm choice to facilitate answering the research question.

[32] The primary purpose of an inductive approach to research is to gather themes or categories that are then developed into broad patterns, and these broad patterns are then developed into theories or generalisations, gradually moving towards an end point (Creswell and Creswell, 2018, p.63).

There are important underlying distinctions between quantitative and qualitative approaches to research (Creswell and Creswell, 2018, p.18). Quantitative approaches collect data that can be counted or conveyed numerically, appropriate for answering research questions involving surveys, questionnaires and polls that can then be analysed using statistical computer programmes (Creswell and Creswell, 2018). Questionnaires or instruments developed by other researchers such as tests, surveys, or checklists, are utilised to collect data. Conceptually, quantitative research is concerned with discovering facts about social phenomena (Creswell and Creswell, 2018). It is an approach that assumes a fixed reality, establishing general laws of behaviour and phenomena across different contexts that can be measured. Research is used to test a theory established at the outset; the outcomes of which either support or reject that theory (Guba, 1981). Quantitative research asks questions such as 'how much? or 'how many?' and is underpinned by a realist ontological philosophy, where one single reality can be studied and measured (Moon and Blackman, 2014).

Qualitative research, however, is the study of people and groups in their natural setting, and attempts to make sense of, or interpret, phenomena in terms of the meanings people bring to their experience in the real world. Conceptually, information is gathered by talking directly to people and seeing them in their natural setting (Smith, Flowers and Larkin, 2009). The aim is to understand the social reality of individuals, groups, and cultures, and to explain a particular phenomenon or behaviour in a particular context. Data can be collected in many forms, such as diary accounts, observations, interviews, focus groups and case study research (Creswell and Creswell, 2018). The researcher *is* the key instrument for the collection of data in qualitative research. Data emerges from a process which aims to provide a detailed examination of the lived experience of those being studied. Qualitative research asks questions such as 'how?' or 'why?' and is underpinned by the central relativist philosophical tradition that no one reality exists; that reality is relative according to how individuals experience it (Yardley, 2000).

The qualitative approach chosen for this research involved decisions related to the philosophical assumptions and methods of data collection and analysis procedures, which are discussed and expanded upon in the next section.

Ontology

It was important to outline the philosophical orientation that underpins the research method chosen. Ontology is the study of reality, and the differing approaches or categories of reality. To consider what counts as the nature of reality it is necessary to confirm the social position regarding the reality being adopted for a study. In the early part of the 20th century, Edmund Husserl (Smith, Flowers and Larkin, 2009) introduced a system of generalised views of the world, which he termed either realist or relativist. Realist ontology believes that there is one single world view, which can be studied; that a real world exists independently of human experience. Relativist ontology, however, believes that reality is constructed within the human mind, that reality is relative according to how individuals experience it; that no one world view exists (Moon and Blackman, 2014).

The intension in this study honoured relativist ontology, guided by the belief that knowledge, truth, and morality exist in relation to cultural, societal, and historical contexts. There is no absolute truth, but different people can have different views and ethical truths that are dependent on the individual or groups holding them (Moon and Blackman, 2014). Thus, a relativist position was adopted, that harmonised to the researcher's therapeutic model.

Having adopted a relativist position, it was necessary to ensure that the philosophical assumptions intrinsic in epistemology were consistent with the ontology, since it is woven into all aspects of this study's validity, scope and methods in acquiring knowledge, and the extent to which transferability of this research can best be assessed (Moon and Blackman, 2014).

Epistemology

Epistemology is the study of (or an attempt to discover) knowledge (Moon and Blackman, 2014). The epistemological stance that guides this research study is important because it shaped how the author framed the research in their attempt to

answer the research question. This research study is in a constructivist paradigm.[33] A stance of constructivism guided this research in the author's attempt to answer the research question (Moon and Blackman, 2014). The goal of the researcher is to rely on the participants' subjective views of their world experiences (Creswell and Creswell, 2018). Just as participants construct their understanding and knowledge of the world, so too does the researcher. The researcher recognises that her background, history, and cultural experiences shape and influence the participants' interpretations. The researcher's intention to make sense of (interpret) meanings that others have about their world is discussed fully in the section exploring reflexivity (pp. 14-17).

The three-tiered philosophical, ontological, and epistemological stance of this research study was shaped and informed by the researcher's psychotherapy model, theory, and practice. Psychodynamic psychotherapy focuses on the unconscious and past experiences, which are thought to determine current behaviour. The basis of this type of therapy is within the context of relationships. Contact with others then, is a basic need, within a dynamic inner world of conscious and unconscious processes that affects how we perceive and experience our reality, informed primarily by early relationship experiences to one's caregivers. Every new relationship is filtered through the lens of early formed relationships. It is an approach embedded in constructivist and relativist philosophy; people actively construct or make their own knowledge and reality, determined by one's learned experiences formed within relationships. Qualitative research is an approach for exploring and understanding the meaning individuals attribute to their experiences, informed by everything learned in their past; just as the therapist is informed by everything learned in her past, which will surface within the therapeutic relationship.

Having presented the philosophical underpinning for this research thesis, the next section provides the researcher's rationale for the methodological approach selected as the framework for the study.

[33] There are three main epistemological paradigms: objectivist, constructivist, and subjectivist (Moon and Blackman, 2014). These three divergent paradigms shape research in very different ways.

Methodology

As previously outlined, IPA explores, describes, interprets the meanings people assign to their experiences, which synthesises to the philosophical stance of this research study (Tuffour, 2017). The theoretical underpinnings of IPA are phenomenology, hermeneutics, and idiography, which are discussed next. This section also outlines the primary method of data collection and sources of analysis to substantiate the method, including a section providing the rationale for selecting the methodology and why some options were discounted.

Interpretive Phenomenological Analysis (IPA)

IPA has a two-stage interpretation process: phenomenology uncovers meanings and hermeneutics interprets those meanings (Pringle et al., 2011). IPA's idiographic emphasis enabled the study to focus on the individual, highlighting the unique personal experience of human nature. Usually, IPA studies have a homogenous sample,[34] however for this study, a small group of women who shared a similar experience were purposely selected and interviewed, to draw on data from each individual who had experienced sexual assault PTSD in common, to develop an understanding from comparing those accounts and establish the shared understanding of the same phenomenon (Smith, Flowers and Larkin, 2009, p. 49. Moreover, IPA is concerned with detailed individual experiences from smaller samples (Smith, Flowers and Larkin, 2009), which was more in keeping with this study's aims.

This research study was underpinned by relativism; a theory embedded in IPA methodology, which claims that different people have different views of the world that are dependent on their experience. Since the focus of IPA is on the lived experience of individuals, its epistemological foundations cannot be structured around an objectivist paradigm; that would be appropriate only if the ontological frame of the research question was a realist one. IPA requires a constructivist epistemology because constructivism rejects the idea of objective 'truth'. Meaning arises from one's

[34] A group of participants who share or represent a particular perspective or phenomena in particular contexts (Smith, Flowers and Larkin, 2009, pp.49-50).

engagement with one's reality, and in one's world (Moon and Blackman, 2014). IPA is concerned with how phenomena appear *and* the individual's subjective world view.

The use of IPA offered the potential to explore the influences of four individuals who disengaged early from sexual assault PTSD therapy and to ask why. This research study aimed to understand what that given experience was like (phenomenon) and how those individuals made sense of it (interpretation of the phenomenon).

Having examined and considered the choice of IPA for this research study, the next section considers the philosophical underpinnings of IPA and their influence on the methodology, data collection and analysis. As previously mentioned, conceptually, IPA is informed by three key areas of philosophy: phenomenology, hermeneutics and idiography (Smith, Flowers and Larkin, 2009). An appraisal of these three philosophical areas in the next section will build on the epistemological position of the research, exploring and justifying the choice of IPA for this research study.

Phenomenology

Phenomenology is a philosophical approach to the study of the *lived experience*, i.e., what it is like to be human (Smith, Flowers and Larkin, 2009). As previously mentioned, Edmund Husserl (1927) is central to phenomenological philosophy, having introduced the term 'intentionality' to reflect the idea that an individual's experience can be perceived subjectively (Santiago et al., 2020).

The depth and quality of phenomenological methodology provides a clear argument that offered the possibility of exploring the participants' experiences that can more achieve the aims of this research study and in answering the question. The following section, outlining the philosophical context of hermeneutics and its bearing on the choice of phenomenology for this research question (Moustakas, 1994; Smith, Flowers and Larkin, 2009).

Hermeneutics

Hermeneutics is a methodology of interpretation that is focused on the subjective experience of individuals (Suddick et al., 2020). Martin Heidegger (1919) was associated with hermeneutics and existentialism[35] in phenomenological philosophy. Heidegger moved us towards a theory of interpretation, focusing on the personal involvement each of us has in our lived experience, *and* in our relationship to the world and others. This important shift in how we think about phenomenology is integral to IPA methodology.

Heidegger's theory of interpretation is contextually bound in individual's experience of being in the world, which is a meaning making human activity (Eatough and Smith, 2017). Husserl describes an ontological perspective in his philosophy emphasising the essence of phenomena revealed through eidetic reductions, the aim of which is to identify the basic components of phenomena (or experience) to reveal knowledge about how things are in the world. Moving from consciousness to concrete objects, essence is revealed by intuition of the eidos (from the Greek word to 'shape'), thus, to shape or comprehend meaning (*eidetic reduction / philosophy / Britannica*, 2017). This dual framing of Heidegger and Husserl's theory captures the primary phenomenological and hermeneutic objective of IPA: to get as close as possible to individual's experience of the phenomenon and the meanings individuals attach to the experience (Eatough and Smith, 2017).

Hermeneutics is the study of theories of interpretation, and it is a specific approach and method for interpretation in IPA (Alase, 2017). The heuristic framework is bound in the researcher's interpretation of an individual's thinking, that is, how the researcher perceives the participant to be making sense of the phenomenon (Smith, Flowers and Larkin, 2009). This is the double hermeneutic in IPA, which illustrates the dual role of the researcher. Like the participant, the researcher is a human being, drawing on her own everyday experiences in making sense of the world. However,

[35] Søren Aabye Kierkegaard (1813–1855) was a Danish Christian philosopher and widely considered a founding figure in existentialism whose writings serve as cornerstones for what would be called 'existentialism' by later philosophers. Heidegger's existentialism then, is the meaning of authentic existence, the significance of our mortality, and our place in the world and among other people as individuals (Deurzen, 1998).

the researcher is not the participant, and only has access to the experience as reported by the participant. Thus, the researcher engages in double hermeneutics, trying to interpret participants' sense making of their experiences. The researcher assumes a central role in analysis of the participants' experiences, intuitively seeking to examine the surface meanings by reading in between the lines for deeper interpretation (Smith, Flowers, and Larkin, 2009).

IPA is a methodology concerned with the lived experience of an individual, and interpretation is the meaning the individual makes of that lived experience. The final major influence of IPA's methodological trine is idiography, as reviewed in the following section.

Idiography

To understand the idiographic approach to IPA, we first have to understand its opposite, namely the nomothetic approach. The nomothetic approach focuses on establishing generalisations that apply to all populations (Smith, Flowers and Larkin, 2009), and it is used when researchers are interested in studying similarities between people. Idiography, in contrast, is concerned with the particular, when researchers are interested in discovering the detail of what makes individuals unique. The objectives of idiographic and nomothetic approaches also have different research foci. The idiographic emphasises the subjective experience of the individual, which allows researchers in-depth insight into individual behaviour that favours qualitative methodologies. Nomothetic approaches draw on universal conclusions and generalisations from groups or populations, and researchers often use quantitative techniques to analyse data (Smith, Flowers and Larkin, 2009). Though seemingly divergent, idiography can form the basis of research objectives using quantitative or qualitative methods (Robinson, 2011).

Criticism of the idiographic approach is based around the history of research within the field of psychology and 'science'. The well-established nomothetic approach is accredited in the training of psychologists (Yardley, 2000), enabling psychology to develop a 'scientific' methodology that can be empirically tested (Yardley, 2000). Idiography is more difficult to define because it embraces many methodologies that

have their origins in phenomenology. It is also a relatively young approach as it is not built on those traditions underpinned by a nomothetic approach. Yardley et al. (2000) suggest that this can have the undesirable effect of setting a nomothetic precedence, since researchers may, arguably, choose a nomothetic approach because it is traditionally seen as more reliable, and with its empirical and precise measurements, predictions and investigations are seen to be more evidence-based.

Further criticism of the idiographic approach is that it is seen to be unscientific (Robinson, 2011), because it is not sufficiently evidence-based, i.e., it cannot produce general predictions about behaviour and if it does, they are limited. The nomothetic approach, however, can make general predictions about groups, but it has been criticised for losing sight of the whole person, which is a particular strength of the idiographic approach. Moreover, evidence-based processes are embedded in idiography, evident in research techniques such as reflexivity, which can improve transparency in the researcher's subjective role, both in conducting research and analysing data to identify and minimise researcher bias in the outcomes (Darawsheh, 2014).

The choice of which approach is more suited to answer the researcher's aim and objectives depends upon their research question. A research question aimed at discovering themes and similarities (or differences) within a group, community, or culture, might incorporate a nomothetic approach, to establish the group norms in the outcomes. However, if the researcher wishes to explore an individual's experience, then an idiographic approach might be appropriate, since it focuses more on the individual's experience. IPA methodology is underpinned by idiographic objectives, and so offered an appropriate alliance for obtaining optimum outcomes for the study's proposed research question.

This section has covered the philosophical underpinnings of IPA methodology. The next section introduces the rational for selecting IPA.

Rational for Selecting IPA

Alternative Methodological Approaches

Several qualitative methodological approaches were considered as suitable for answering the research question. For example, Grounded Theory (GT) is one of the most widely used approaches in qualitative research since its emergence in the 1960s (Glaser and Strauss, 1967; Strauss and Corbin, 1977; Glaser and Strauss, 20001997; Charmaz, 2014). GT honours an inductive approach to analysis, constructing theory and concepts to gather emergent themes (Sage pubs, 2007). Bryant and Charmaz, 2010). GT is theory-driven in its approach, concentrating on establishing theories from which to build a theory around participants' experiences. Conceptually, the framework of GT features the development of categories or themes, from which the researcher continually draws constant comparisons from across participants, drawing on larger samples to support wider theoretical explanations. IPA is not merely a methodology; it is also a philosophy that pays close attention to participants' subjective realities. Creating a theory was not the focus of this study however, but rather extracting and defining the *meaning*[36] that participants attribute to particular experiences. IPA provided a more compatible method with this study's research aim, since it offered an opportunity to examine the lived experience of the participants in detail (Smith, Flowers and Larkin, 2009). In summary, IPA attempts to understand the subjective life experiences and perspectives of participants in a research study, whilst GT is a research methodology that involves the construction of theory through the analysis of data. IPA analyses and evaluates life experiences, whereas grounded theory develops theory from evaluative phenomena.

Narrative approaches have been developed by key figures, including Labov (1997), Polkinghorne (1988), Clandinin and Connelly (2000), and Riessman (2008). Narrative analysis refers to the way in which individuals construct their own self-accounts through the creation and use of stories to interpret the world (Burck, 2005). This

[36] In IPA research, our attempts to understand other people's relationship to the world are necessarily *interpretive* and focus upon their attempts to make *meanings* out of their activities and to the things happening to them (Smith, Flowers and Larkin, 2009, p.21).

approach shares commonalities with IPA in its social constructivist process, however, unlike narrative analysis, IPA is not restricted to this focus alone (Smith, Flowers and Larkin, 2009). Narrative approaches make broader claims, and without the meaning-making of phenomenology. Narrative inquiry is research through story and how the story is told and unfolds. Meaning is constructed through negotiation and collaboration between the participant and the researcher. This study was not interested in dissecting the structure of the stories that people tell but sought to explore a shared phenomenon to examine and understand the meaning that those who experienced that phenomenon gave to that experience.

IPA methodology views people in-context, expressed in their dynamic, and interactive experiences. Individuals' experiences are unique, accessed only through interpretation of their accounts. Interpretation in IPA is focused on the meaning participants attribute to their experience; aspects of the phenomenon the person represents, and its significance to them (Smith, Flowers and Larkin, 2009). IPA does not rely on psychological theories to collect and analyse data: though it is data-driven, the personal experience is emphasised (Smith, Flowers and Larkin, 2009).
Intuitively, IPA is an influential method in research, not only in terms of the interview process but for the psychotherapeutic process; as IPA allows for exploration of change and giving voice to individuals unique experience and intersubjective meaning-making processes (Larkin and Thompson, 2012). Framed within a constructivist paradigm alliance, where one's learned experiences are determined and formed within relationships (Moon and Blackman, 2014), is cogent in psychotherapy research allowing for exploration of the clients' perspective, the meaning they attribute to phenomena, or how they conceptualise the psychotherapy process, for outcomes that can be useful for incorporation into everyday clinical practice (Binder et al., 2010; McLeod, 2011; Midgley et al., 2014).

Having considered different qualitative methodological approaches and justified why IPA is most suited to this research study, the next section outlines the role that reflexivity played, and why it was central to the rigour and transparency of the analysis and outcomes of the study.

Reflexivity

Silverman (2016) establishes reflexivity as important in recognising that researchers are part of the world being researched. Consistent with other qualitative methodologies, the IPA researcher has the potential to influence the participants involved in the study and so to achieve a more neutral position, reflexivity was adopted to identify areas of potential bias and 'bracket' them so that their influence on the research process was minimal (Ahern, 1999).

This qualitative research study incorporated face-to-face interviews with participants. To guard against the schism of the 'researcher and the researched', the researcher needs to reconcile two opposing attitudes to the research, namely, detachment and involvement (Costly, Elliott and Gibbs, 2010). Adherence to detachment enabled the researcher to adapt to the realities and experiences of the participants being observed, whilst at the same time being mindful of affecting the material. Triggers, identification, and countertransference reactions were recognised as much as possible to avoid contaminating the quality of the participants' material.

Reflexivity influenced each step of this research process, from relationships with service managers and work colleagues, recruiting participants, and answering the research question, to factors such as age, ethnicity, life experience, education, and personality. Insider privilege is a valuable position for a researcher. The depth of knowledge that can be incorporated into the research study, as well as articulating the researcher's position in a transparent way, allows others to reflect on and manoeuvre within their own constructions and representations of the research (Costley, Elliott and Gibbs, 2010).

The next section examines reflexivity in the context of researcher positioning and work-based research.

Reflexivity, Researcher Position and Worked-Based Research

The role of reflexivity in work-based research is integral to the researcher's position including her values, beliefs, interests and ambitions that might shape the research interest and thus its focus (Cousin, 2013). The researcher's ability to remain reflexively conscious of influencing or shaping the tenets of the research was essential regarding the participants. From an outsider's perspective, the researcher seems to hold all the cards as it were, aptly described by Råheim et al., (2016, p. 2), "The privileged position of the researcher…[and]... The inherent power imbalance between the parties and the ethical concerns pertaining to this imbalance [must be] dwelled upon..."

Anticipating ethical issues was important because it reflected the researcher's ability to think about their position in the context of their workplace and how that might influence the research process. The privileged position of the researcher as the clinician, professional or the expert might be considered subjective, especially since they represent their organisation and work colleagues, as well as the participants, and how that informs their response to questions (Costley, Elliott and Gibbs, 2010). Subjectivity in research is considered detrimental to good outcomes, hence the necessity to remain objective, detached, and impartial. Reflexivity is integral to guard against developing relational imbalances, and to remain conscious of all aspects of researcher influence that link the researcher to the study directly (Creswell and Creswell, 2018).

The next section outlines researcher position in relation to the research study, and how the researcher's past experiences can shape and influence her interpretations of the participants' accounts.

Reflexivity, Researcher Position, and the Research Study

The researcher's position in relation to the research study establishes and reflects their beliefs about the world they live in (Kivunja, 2017). Indeed, their worldview will shape the beliefs and principles of the study, which in turn, will be interpreted at all stages of the research. Frank (1997) states that reflexivity involves the realisation that researchers are part of the social world that they study, and so may potentially shape any interpretations being made (Creswell and Creswell, 2018).

My interest in this topic was developed whilst working at the women service (WS), which offered a multiplicity of models of therapy to clients who had experienced sexual assault and had subsequently developed symptoms of PTSD. The WS is committed to women's and girls' rights and champions feminist[37] principles in all its affairs. My therapeutic approach is psychodynamic, however no one mode of therapy is recommended by the WS to treat PTSD. Therefore, the researcher's interpretations were analysed entirely through a psychodynamic therapeutic lens and embedded in feminist principles.

There were some parallels the researcher could draw on with the participants, namely being female, and being familiar with the therapeutic process, including assessment and waiting on a waiting list for therapy, as well as receiving therapy too. However, in the main, the researcher remained outside of the life experiences of the participants and symptoms of sexual assault-derived PTSD. This emphasised the value of engaging reflexively when undertaking interviews, since these processes contributed to reducing researcher bias in developing interview questions, and prevented as much as possible her assumptions, preconceptions, and bias about the participants' experiences from influencing the outcomes of the analysis.

Beliefs are convictions that we generally hold to be true, usually without any proof or evidence. Our beliefs develop from what we see, hear, experience, read and think

[37] Feminism is defined as the belief in the social, political, and economic equality of the sexes (Brunell and Burkett, 2021).

about, beginning in childhood from caregivers, our environment, and our personal experiences and developing as opinions that we hold to be true. Our beliefs inform our values: they are not truths but nonetheless hold true for us, and are the lens through which our actions, behaviour and attitudes towards others and the world are reflected. Belief systems influence society and culture, interacting in religious, political, scientific, and personal groups, in the choices that we make, how we live our lives, and how we interact with others.

Assumptions are based on our values and beliefs. When we make assumptions, we often overlook that they are based on a system of unverified beliefs and values, heavily influenced by our life experience. Our assumptions shape us as individual (Philosophical Assumptions and Interpretive Frameworks (n.d). Thus, an assumption is an unexamined belief: we think it without realising because we have not thought about it critically. Just because we assume something is true, does not mean that it is. Critically thinking about my assumptions, brought my beliefs, values and life experience into sharp focus in this study.

Thus, assumptions are things that the researcher accepts as true, or plausible, that may not be true. For example, when the researcher embarked on this research journey, she retrospectively held three significant assumptions about the research. The first was that disengagement from therapy was problematic in the WS only; the second, that the trauma-informed approach or model in the WS was not meeting the clients' needs; and thirdly, that there was a socio-political influence linked to funding resources in the Violence Against Women and Girls (VAWG) sector. The researcher's work experience, training, and professional development were informed predominantly by her working environment. When the researcher began reading journals in the field of disengagement, it quickly became apparent that disengagement had been a burden within mental health services for more than 50 years, across all mental health disorders, within all models of therapy, and nationwide. Furthermore, the funding contention was not a factor of disengagement in the WS per se, however the complexities of disengagement were entrenched in a macro-wide divide in mental health service providers, between the dominant countries of western Europe, and the rest of the world, in the development of trauma-informed treatment approaches and disengagement. The researcher's assumptions, held at the beginning of her thesis

research were erroneous and invalid. It was necessary to stop and critically examine those and other assumptions; to view therapy disengagement from a much broader perspective.

Thinking critically revealed my own beliefs and philosophical assumptions about the research study, for example, the questions to ask and how to go about gathering data. My beliefs are woven into all the choices made in this study, influenced by my education, work experience, training and therapeutic model, as well as professional development through reading journal articles and books, advice given by advisors, and the scholarly communities I engage in (Guba and Lincoln, 2005). The philosophical assumptions of ontology, epistemology, and methodology associated with the interpretive framework of qualitative research methods, involves a detailed understanding of the subject through observation, to get as close as possible to the participants being studied. The research paradigm and beliefs that the researcher brings to the process of research, and the theoretical orientation that guides the researcher to interpret her data in a particular way, are informed by the researcher's assumptions about her world. A critical evaluation of the researcher's assumptions is vital both for the study, and for reviewers and readers, to assess the rigour, quality, and usefulness of this qualitative research (Guba and Lincoln, 2005).

Bracketing

In reflexive practice, the researcher is required to probe and question the way she views *her* world and *her* social conditions, so that researcher bias is reduced as much as possible (Silverman, 2016). To demonstrate the validity of both the data collection and the analytical process, and to stay close to IPA's idiographic commitment, bracketing was incorporated. Bracketing is the practice of suspending judgement of one's own world experiences to see more clearly those of others (Smith, Flowers and Larkin, 2009). Thus, the researcher endeavoured to integrate bracketing into each step of the research process as an additional layer of protection, guarding against researcher bias in both data collection and the process of analysis (Gearing, 2004). The practice of bracketing is therefore an iterative, reflexive journey, or as Ahern (1999, p. 410) states, 'fruit from the same tree'.

Collection of data from interviews affords the researcher a unique opportunity from which to make interpretations about the perspective of the participant. However, Tufford and Newman (2012) suggest this process is inherently subjective because the instrument for the analysis of each step of the research *is* the researcher (Starks and Trinidad, 2007). This subjective undertaking will inevitably imbue the assumptions, values, interests, emotions, and theories of the researcher into the entire research process, which will in turn influence how data are gathered, interpreted, and presented.

There are a number of contentious issues surrounding the practice of bracketing in phenomenological research, most notably which elements of the process a researcher should include, as guidance from the literature is unclear. However, there is consensus regarding which of the researcher's beliefs, values and biases ought to be suspended, though authors either tend to extend or interpret the practice of 'bracketing' according to their own research remit (Tufford and Newman, 2012). For example, Gearing (2004) states that the researcher's history, knowledge, culture, and academic reflections, such as orientation, are further elements to include in bracketing. Lack of consensus continues to be debated in the research literature (Tufford and Newman, 2012).

A further contentious issue surrounding the process of bracketing is the point at which bracketing in the research process should occur. In most cases, bracketing in phenomenological research is undertaken during the data collection and analysis phase so that the researcher demonstrates validity in the process (Chan, Fung and Chien, 2013). However, there is a lack of consensus in the literature as to when bracketing should occur within the context of the research, as some authors suggest bracketing should begin only at the analysis stage, whereas others advocate it should be incorporated at the start of a project and practiced throughout. (Rolls and Relf, 2006, cited in Tufford and Newman, 2012).

The matter of when to begin bracketing in phenomenological research then, is linked, in part to the iterative nature of the process of analysis; Tufford and Newman (2012) describe this as the 'cascading nature of qualitative research ... The formation of research questions proceeds to data collection, which in turn proceeds to data

analysis' (p.85). With each stage or process of the research informing the next, researcher bias and assumptions can develop at any stage. Thus, the risk of only bracketing at the analysis or the data collection stage is that researcher preconceptions can come to light and filter into any of the research, with the possibility of compromising the entire project.

Bracketing in this research study began *before* entering both the data collection and analytical processes, to reduce as much as possible any influence of researcher bias. The methods chosen for the practice of bracketing in this study included memo notes and journaling, which began at the conceptual stages of the research process and continued throughout the data collection and analysis processes as a means of examining and reflecting upon the researcher's engagement with the data (Cutcliffe, 2003). Memos took the form of theoretical notes and observational comments that allowed the researcher to uncover her feelings about the research, and to remain conscious and observant of researcher preconceptions and bias (Smith, Flowers and Larkin, 2009).

Central to IPA is the researcher's attempt to understand as much as possible about one interview transcript before moving on to the next. Analysis from the first interview is set aside (as far as is possible) by means of bracketing, to maintain a boundary between one transcript and the next (Smith, Flowers and Larkin, 2009). Systematically following the guidelines for the process of analysis outlined in Smith, Flowers and Larkin (2009), ensured that any influence from analysing one interview transcript to the next was significantly reduced, with the practice of bracketing continuing throughout the data process.

The discipline of reflexivity and incorporating bracketing throughout the research study enabled the researcher to produce reliable and rigorous data, avoiding as much as possible incorporating only those elements that fit with the researcher's views, preconceptions, and assumptions. The personal experiences of the researcher, as a psychotherapist, may contribute to the study methods addressed and to the value of critical reflexivity.

The idiographic commitment was explored as justification for utilising IPA to analyse the data in this research study. However, the study outcomes can only be seen in light of some of its limitations, which are explored in the next section.

Strengths and Limitations of IPA

Five main areas of concern are now considered regarding the limitations of IPA, which will aid in transparency of the analysis of the data, in presenting realistic expectations about what IPA can, and cannot, achieve in the study.

(1) Language

For the researcher to gain insight into participants' experiences, the researcher must understand that their accounts are inextricably bound in the language that constructs their reality (Tuffour, 2017). Thus, IPA analysis presupposes that participants are equipped with the language to both capture the experience and convey it. However, Eatough and Smith (2017, p.66) states that the constructions of reality can only be a representational validity of the language used, that validity of experiences and meaning making inhabit the words themselves and therefore direct access to the participants' experience is impossible. The role that language plays in IPA is discussed further in the second limitation of IPA analysis; the suitability of participants.

(2) Suitability of Participants

Interview transcripts can only really show us the way a participant talks about a particular experience within a particular context, rather than about the experience itself (Willig, 2013, p.67). For example, the same experience or event can be described by a participant in many ways because they choose the language to construct a particular version of that experience and describe that experience at that particular time. This was one of the reasons that exclusion criteria were established early in the recruitment phase of this research project. Volunteers to the study, who did not have English as their first language, for example, could have missed the

nuance and subtleties when being questioned about disengaging from therapy, compounded by difficulties expressing and articulating their responses, and exacerbated further by the psychological language of sexual assault-derived PTSD therapy. IPA presupposes a richness of response from the lived experience of participants that might not have been available due to any potential complexities of enduring symptoms of PTSD and/or participants' language confidence and skills.

To accurately capture the experiences and meaning making of participants' experiences, rather than merely descriptions or opinions, both the participants and the researcher need to have the required language skills to communicate their experiences, which may not be the case (Tuffour, 2017). It was stated earlier in this chapter that the researcher *is* the data collection 'instrument' in IPA, and as such, it was important to remain attentive to any language limitations during this process and to collect a body of rich data, whilst remaining mindful of her influence on its interpretation with ongoing reflexive practice.

(3) Samples

The third limitation and an often-cited criticism of IPA and qualitative research in general, is that sample sizes are generally small, between three and six participants (Smith, Flowers and Larkin, 2009). However, samples in IPA are purposefully selected to provide the richness and depth of responses required of the phenomenon under investigation (Vasileiou, et al., 2018). Therefore, samples in IPA are representative of a perspective, rather than a population. This study was not concerned with making general claims about a population (as in nomothetic approaches), but rather to understand the perspective of a group of people in a particular context (Smith, Flowers and Larkin, 2009). Guidelines on sample size determination for IPA are clearly outlined in Smith, Flowers and Larkin (2009), and is a feature that is intrinsic to the study, and in agreement with general advice. The lack of statistical generalisability in IPA does not negate the ability of qualitative research to be valid and relevant beyond the sample studied (Yardley, 2000).

(4) Idiographic Commitment

The idiographic commitment in IPA and the search for connections across participants' transcript data can create some tension for the researcher. The commonality of participant experience (or phenomenon) can obscure individual differences between participants about their experience. There are, within the analysis, opportunities for discussing developing themes that diverge between participants (Wagstaff, et al., 2014). Moreover, in sample sizes of four or more, there is less opportunity to generate unique themes within the idiographic parameters.

Smith, Flowers and Larkin (2009, pp.106-107) emphasise that measuring recurrence of emergent themes across participant interviews is important. Hence, for a theme to be classified as recurrent, it must be present in at least, and in the case of this research, three of the four participant interviews (and ideally be present in all four participant interviews) to optimise validity of the findings. Whilst there is some tension in honouring the idiographic commonality of themes across participant interviews, this IPA study was focused on a specific topic, namely a phenomenon that was shared by all four participants involved. Erickson (1986) suggests that evidence in naturalistic inquiry can be understood in terms of adequacy dimensions. For example, in terms of amount and variety of evidence, its interpretive and disconfirming status, as well as its variance (convergence and divergence) between participant analysis, eliciting both individuality of participants and shared experience of the phenomenon (Erickson, 1986, pp.72-73). Emerging themes in the findings for this study allowed for richer and deeper interpretations and engagement in the participants' lived experience for a thorough exploration of the topic (Arroll, 2015, pp. 48-49).

(5) Replicable Outcomes and Transferability

Replicable outcomes are those that are potentially transferable to other contexts, times, and samples. The degree to which results can be generalised to a wider population invites readers of the research to make their own links between essentials of the research and their own experience, and if the phenomenon being studied provides them with evidence that the research study could be applicable if the study

was conducted again in a different context and setting and with different participants (Yardley, 2000).

Erikson (1986) states: "The main function of reporting general descriptive data is to establish the generalisability" (Erikson, 1986, pp.108-109). Three techniques to ensure reliability were utilised in this study that provided a framework for comparison and transferability, and rich, thick,[38] detailed descriptions for external validity. The first strategy was giving a detailed account of the study's focus, the researcher's role, the basis and role of participant selection and the context for data collection. Secondly, a clear outline of the methods of data collection and analysis showing reliability and internal validity, were presented. Lastly, data collection and analysis strategies were reported in detail, with a clear and accurate description of the methods used (Merriam, 1988, cited in Creswell and Creswell, 2018).

Critical self-reflection and awareness of the psychotherapy practitioner were vital in this study because of the centrality of their position as researcher, thus ensuring a reflexive approach.

Strengths and Limitations of Methods

Consideration was given to the influence of the author's preconceived bias and assumptions, particularly in relation to recruiting the interviewees, the interview itself and my responsibility to minimise any possible disruptive effects of my own interpretation of interviewee responses on the overall outcome of the study. Consequently, the socially constructed accounts that emerged were based on the participants' perspective of their own reality.

The next section outlines the primary methods of data collection.

[38] Thick description is intensive, small-scale, dense description of social life from observation, through which broader cultural interpretations and generalisations can be made. The term was introduced in the philosophical writings of Gilbert Ryle and developed by Clifford Geertz in anthropology (Oxford Advanced Learner's Dictionary of Current English, 1995).

Methods of Data Collection

This section outlines the primary method of data collection, including a description of the ethical considerations and the data collection process, participant recruitment, selection, sampling and verification techniques. It concludes by outlining the devices used for trustworthiness, validity, and verification of the analytical procedures.

Ethical Conduct and Process

The following section provides an overview of the ethical considerations for this research project, outlining how participant wellbeing relating to vulnerable groups was preserved, including details of participant selection, consent, safeguarding and confidentiality.

The matter of reflexivity outlined in this chapter earlier, considered the possible influence of researcher bias and assumptions in relation to all stages of the research process.

To ensure informed consent, potential participants were given a detailed explanation of the study and sufficient time to consider the information before agreeing to take part. To avoid coercion, it was made clear that participation was entirely voluntary, and participants could withdraw from the study at any time without repercussions.

Permission from the WS was sought and granted for the researcher to:

- offer individuals' re-referral to the WS for therapy for those who consented to being involved in the project.

- have access to the database for assessments and for tracking individuals' therapy contact.

- use the WS Head Office venue for interviews, so as to conduct them in a safe and secure area.

- Screening questionnaire questions were approved.

Ethics

Permission was granted by the clinical management team at the WS to conduct research on clients who did not complete the full number of therapy sessions offered. Following this, an application was presented to the CPP Research Ethics and Governance Committee in November 2014 (Appendix 8) and ethical approval was gained.

Since this research concerned human subjects, adherence to ethical principles was observed to protect their dignity, rights and welfare. Review by the Research Ethics and Governance Committee ensured the appropriate ethical standards were being upheld, as outlined according to the ethical considerations of:

- Informed consent.
- No harm should come to the participants.
- Respect for participants' anonymity and confidentiality; and
- Respect for participants' privacy.

All personal data, records and personal information of participants involved in the research study were stored in line with The Data Protection Act (1998) and to comply with more recent General Data Protection Regulation (GDPR) guidelines (University of Kent, 2018).

As a psychotherapist, the researcher also adheres to the UK Council for Psychotherapy's (UKCP) Code of Ethics and Professional Practice (2019) guidelines.

Ethical Concerns

To address the ethical challenges of researching this study group, two important areas were considered. The first was to acknowledge the risk of individuals becoming re-traumatised by the research interview, and the second was to provide adequate intervention to limit that possibility. Both considerations were met, and a pre- and post-care plan was put in place, as outlined in the following section.

Potential Risk to Individuals

Ethical concerns relating to the risk and safety of the individuals involved in the research were addressed in collaboration with the clinical service management team to reflect the ethos of the organisation. Thus, steps to maintain the personal safety of individuals during data collection were as follows:

1) Recognise potential risks for individuals approached for interview

Since the individuals were no longer in the WS system and therefore, no longer supported by the organisation, the following risks were identified:

a) Vulnerable group set.
b) Risk of re-traumatisation; and
c) Need to provide support and/or signposting for further support.

2) Reduce the risk to individuals who participated

The following safety measures were put in place to reduce the risks to individuals:

a) Transparent and clear documentation of what to expect should individuals choose to participate in the research.
b) An awareness that involvement in the research project did not constitute therapy or further support from neither the WS, nor the researcher.
c) Development of a screening questionnaire to highlight any risk.
d) Appropriate support and signposting was available to individuals.

e) Agreement from the WS that individuals who volunteered to be involved in the research could re-refer to the WS for one-to-one therapy should they wish to do so; and
f) Agreement from the WS that clinical rooms at their Head Office premises could be booked to ensure a secure and confidential space for conducting and recording interviews.

3) Safeguarding

Three areas of concern around safeguarding were recognised:

a) Screening questionnaire was developed to assess individuals who volunteered but who were deemed too vulnerable to take part.
b) Availability of therapy support and re-referral for individuals; and
c) Maintaining confidentiality:

Ensuring Confidentiality

Ensuring confidentiality meant the researcher did not disclose the identity, personal information and responses of the participants to anyone outside of the research team.

Protocol for Breach of Confidentiality

Breach of confidentiality is a potential risk of participating in research. Participants were informed and notified of how their information was to be stored during and after the study. To protect participants' confidentiality, computer-based files of all sensitive data were password-protected in zip files; all printed and hard copy documents (i.e., signed consent forms) and Dictaphone notes were stored in a locked drawer, ensuring removal of personal identifiers from study documents as soon as possible. Confidentiality was communicated to the participants before the interview, and prior to signing the consent form.

Data Storage

UK Research and Innovation (UKRI) best practice recommends that data underpinning publications should be accessible for at least 10 years after publication.

All personal research information was to be stored for the duration of the study, and for a minimum of 10 years post completion.

Distress Protocol

Should a participant become distressed at any point during the interview, a four-stage distress protocol was established to reduce possible risk, as follows:

I. The researcher identified potential volunteers from the inclusion criteria to reduce potential risk of psychological or emotional distress.

II. A screening questionnaire was developed as a secondary tier to reduce risk to volunteers prior to inviting for interview.

III. The researcher communicated to the volunteers at the beginning of the interview that should they become distressed during the interview, or if the researcher recognised their distress, the interview would be terminated (the researcher actively monitored the volunteers during the interview process).

IV. Should a participant suffer adversely as a result of participating in the research, a follow-up procedure was put in place, with support from the WS being made available. The researcher ensured the participants had the researcher's contact details and reminded them that they were free to contact her or the WS, for further support.

4) Accessing confidential information

It was necessary for the researcher to have access to confidential and sensitive information about the individuals to make recruiting possible, and these were outlined to potential participants prior to the interview taking place. These were:

a) The WS tracker excel spreadsheet.
b) The WS database.
c) Clients' assessments and assessment outcomes; and
d) Voice recordings and transcriptions of interviews.

The next section outlines the method of data collection for this research study.

The Research Process

Semi-Structured Interviews

A semi-structured interview was considered the most appropriate for gathering data, which allowed for open-ended questioning in a conversational style, rather than a more formal question and answer format (Smith, Flowers and Larkin, 2009). This more informal approach to interviewing allowed the researcher to develop meaningful questions ahead of the interview and relevant to the research question, as well as time to prepare for the interview itself.

Semi-structured interviews also allow participants more freedom to express their views in their own terms, allowing the researcher a degree of flexibility when it comes to following the interview schedule. For example, the researcher might ask a question and the participant could answer two of the questions on the schedule in their response. Indeed, for the participant not to repeat themselves, it was more appropriate to follow on from the answer given by the participant (Smith, Flowers and Larkin, 2009). This fluid interview style encouraged a more 'natural' interaction between the participant and researcher and enabled them to engage in a dialogue where questions could be modified considering the participants' responses, also allowing the researcher to gather ideas from other potentially interesting areas that might arise (Smith, Flowers and Larkin, 2009).

A limitation of semi-structured interviewing is that it brings into focus the skill of the interviewer and her ability to think of questions during the interview and 'in the moment'. Moreover, the interviewer may send unconscious cues that guide participants to respond to questions. Furthermore, though pre-set questions were prepared by the researcher, participants' may have been asked different/other questions during the interview, depending on their responses. Non-standardised participant responses can yield a quantity of data that can be difficult to analyse, especially with smaller samples where participants may effectively be answering a number of different questions. In addition, participants, like all individuals, have imperfect recall. Being asked to recount feelings and thoughts that may have occurred months or even years prior to the interview, including time to reflect on the experience, can compromise the validity of the analysis (Diefenbach, 2008).

An element of researcher bias is inevitable in the interview process, as there is always some risk during the information gathering stage that participants' data could be affected. As such, the researcher sought to reduce any bias with reflexive rigour and bracketing (Silverman, 2016, p. 143), as previously mentioned on earlier in this chapter. Reitz (1999) recognised the importance of incorporating a 'bracketing' technique to reduce as much of the researcher's preconceptions during the interview as possible.

Process of Data Collection

Recruitment

Permission was granted by the WS manager that a statement, written on WS-headed paper and briefly outlining details of the project, could be included with the assessment documentation. Individuals invited to the WS for an assessment were handed the letter at the end of their appointment, informing them that they might be contacted by a therapist working at the WS during their contact with the service (see Appendix 9).

The WS Tracker Report 2015-2016 Excel Spreadsheet

The WS tracker spreadsheet is an electronic 'paper' trail that captures first contact with the WS, to the point where the client is no longer engaged with the service. The status of every client is known, and at what point they are along that in-service process. For example, a client may have disengaged after initial contact with the service and therefore no further action (NFA) would be entered, or the client could remain in the WS's service and be referred for group support.

The WS Database

Once established that a client had been offered a therapy slot, the WS in-house database system provides further information on a client's assessment, checking their outcomes and establishing the number of therapy sessions offered and attended by counting the contact notes for each individual.

Email was deemed the safest and least intrusive way to engage a disengaged client. The email signature had the researcher's contact details and included those of the organisation. A standard email was drafted introducing the researcher and briefly outlining details of the project and what would be expected of them should they wish to participate. The researcher requested they reply if they were interested in participating (see Appendix 10).

If a participant responded, an email was sent inviting them for interview, followed by another email to confirm time and date of their appointment. A further email was sent later in the recruitment process to those individuals who had initially expressed an interest in being interviewed (see Appendix 11).

Individuals were invited for interview at the WS Head Office, and the researcher booked a clinical room once the date and time had been agreed. Before the researcher began the interview, participants were given the information sheet and consent form to sign. Once the consent form was signed, the researcher began the interview by indicating to the participant that the voice recorder was going to be switched on.

Recruitment lasted for 18-months in total, from Jan 2015 to April 2016, in which time individuals were assessed as to their suitability for the project, and if successful, were placed on the waiting list for a 16-week course of one-to-one therapy. Between 10 and 12 weeks of their therapy having commenced, the researcher used the WS tracker spreadsheet to identify the number of therapy sessions each individual had attended.

The WS tracker spreadsheet was checked at three-monthly intervals. Any potential individual identified was cross-referenced with those on the database to confirm the number of therapy sessions attended. If there were less than 16 sessions attended, a further check was made to confirm the last contact made by the therapist to ensure the client was not returning to therapy, and the client was sent the introductory email describing the project. This was a rolling recruitment process; each recruitment process would bring a different number of potential individuals to the project; sometimes three, sometimes seven, so the process varied greatly.

By April 2016, three individuals had agreed to be involved in the project. The minimum stated in the original project proposal was four (maximum of six). Recruitment began again, returning to the WS tracker spreadsheet from January 2015 to follow-up those individuals who had expressed an interest initially, and where contact had ceased or trailed off. This approach successfully identified one further individual who agreed to participate, thus completing the recruitment process in March 2017.

Seven individuals in total agreed to participate in the project, however, three did not meet the inclusion criteria as English was not the first language for two of those individuals, and one had completed 16 sessions of therapy. Hence, all three were excluded from the study.

Screening Questionnaire

A screening questionnaire was developed (see Appendix 12) should the researcher identify individuals thought to be too vulnerable or at risk of being re-traumatised by

taking part in the study. The researcher aimed to gauge those at risk during the interview and discontinue the process if the participant showed signs of distress or requested the interview to cease. Interviewees would also be given details for further support or signposted to another service linked to the WS, as agreed with the service management team. However, the screening questionnaire was unnecessary for the participants interviewed for this research study.

Participants

Participants were selected from individuals who had experienced the phenomenon of interest under investigation, namely early disengagement from sexual assault PTSD therapy (Creswell and Creswell, 2018). Conducting this IPA research study with comparable participants was central for the study, as Creswell and Creswell (2018) states it is essential that all participants have similar lived experience of the phenomenon being studied. To that end, the researcher was able to better gauge and attempt to understand the participants' lived experience of the phenomenon, how they made sense of their experiences and the meanings they attached to them (Smith, Flowers and Larkin, 2009).

The next section outlines the inclusion and exclusion criteria and includes the interview schedule and procedures.

Inclusion and Exclusion Criteria

Inclusion Criteria

Participants were English speakers, and women aged between 25-35 years, who had experienced sexual assault and been assessed as Type 1[39] (Single traumatic event causing stresses) on the Terr Trauma Categories Scale (Terr, 2003). Individuals were

[39] Classification for identifying post-traumatic stress disorder symptoms at the WS is identified at assessment using Terr Trauma Categories (Terr, 2003), as follows:
Type 0 = No current traumatic stress.
Type 1 = Single traumatic event causing stresses; and
Type 2 = Variable, multiple and long-standing trauma events.

offered 16 standard therapy sessions, and each agreed to attend once a slot matching their preferences[40] had become available. Criteria for selection of participants were:

- The participant had attended the assessment and a minimum of one therapy session before disengaging: and
- The participant had attended the assessment and had not exceeded (attended) 16 therapy sessions, except in the case of an approved therapy session extension.[41]

Sessions attended ranged between one and 10, excepting one participant who was offered an extension.

Individuals who participated in the study generally self-referred due to worsening symptoms of PTSD from sexual assault, and impaired quality of day-to-day functioning. Individuals were offered the WS standard 16 'counselling'[42] sessions. At the time of the interviews, participants were living in London, and in full-time employment.

Exclusion criteria

Those excluded were non-English speakers, those who did not return for therapy after completing only the assessment, individuals who had completed 16 standard therapy sessions, those already seen by the researcher for therapy at the WS, and women who were identified as Type 0 and Type 2 at assessment on the Terr Trauma Categories (Terr, 2003) (see Appendix 13 for participant inclusion and exclusion criteria).

Four women who disengaged early from the WS therapy service for PTSD symptoms from sexual assault met the inclusion criteria for the study to ascertain the reasons

[40] A section in the WS assessment pack is dedicated to clients' preferences for attending therapy, including venue, and preferred Borough, time and day.
[41] A therapist can offer a client up to 10 extended therapy sessions (once approved), if justified.
[42] The WS does not distinguish between counsellor, therapist, or psychologist, neither does it distinguish between therapeutic approach, training, post-training experience, etc. All counselling approaches and 'counsellors' are generically termed under the umbrella term 'counselling'.

why they disengaged from therapy early (see Appendix 14 for participant characteristics).

The next section outlines further ethical considerations for the research study.

Pilot Interview

Ethical boundaries were such that it was not possible to pilot the questions with a potential participant. This was due in part to early disengagement and difficulties around recruitment, but more about the nature of PTSD symptoms, sexual assault, and the potential risk of re-traumatisation. However, the questions were discussed with research peers and the supervisor overseeing this research study to mitigate as much as possible any risk to participants (see Appendix 15 for the interview schedule).

Interview Procedure

Prior to the interview, participants were guided by the researcher in what to expect from the interview process. It was made explicit at the beginning of participants' involvement in the study that they would not be asked about their experiences of rape or sexual assault, but rather the questions would remain centred on early disengagement from therapy. All aspects of communication were collaborative and participant-led in attempting to address any concerns, including the potential power imbalance caused by the interviewer's dual role of researcher-therapist (a comprehensive summary of the procedures and ethical considerations are fully outlined in the ethics section of this chapter, pp. 120-125).

Prior to the interview, participants were informed of where the interview would take place and that the interviews would be recorded and transcribed. An information sheet was given to participants at the beginning of the interview in order that they were informed and guided on what to expect.

Information provided for participants was clear and transparent, and care was taken to ensure that individuals fully understood the nature of the study and that participation

was voluntary. A statement was made that confidentiality of recovered data would always be maintained, and identification of individuals would not be available during or after the study. In this regard, the following documents were developed by the researcher and approved as follows:

Participant information sheet (see Appendix 16); and
Participant consent form (see Appendix 17).

Interview Schedule

Questions were prepared prior to the interviews and developed by the researcher in line with recommendations from Smith, Flowers and Larkin (2009). The questions emerged from considering the research question in collaboration with research peers and the project supervisor and were focused on eliciting the best possible responses to provide reliable and comparable qualitative data. Smith, Flowers and Larkin (2009) suggested approximately six to ten open questions would be suitable for a conversation of between 45 and 90 minutes, and so ten were developed (see Appendix 15 for interview schedule).

Funnelling was incorporated to help identify a logical sequence for asking the questions. For example, more sensitive or difficult questions were asked towards the middle of the interview, once the participant was more at ease. Initial questions set the scene, so the question, 'how did you find out about the WS?' encouraged the participant to begin talking about their initial engagement with the WS. Each participant was asked the same set of questions to allow for consistency in the data.

Interviews were recorded and transcribed verbatim using a naturalised approach (Bucholtz, 2000). Any possible identifying information was removed, and each participant was given a unique identifier to protect anonymity and confidentiality, for example, 'Participant 1' was simply coded as 'P1' or '(P1)'. Recordings were stored in accordance with data protection legislation and recent GDPR guidelines[43] (Appendix 18 offers an example of a completed interview transcript for P1).

[43] GDPR https://www.kent.ac.uk/infocompliance/dp/about.html

Transcription of Recorded Interviews

The aim of IPA is to interpret meaning in the content of participants' accounts. Consequently, it was not necessary to include certain aspects of the interview, such as exact length and time of pauses, but laughter was recorded, and hesitations were represented by a set of ellipses.

Verbatim transcriptions of the participants' recorded interviews enabled every word, sound, repetition of words, hesitations, etc. to be captured, which added to the researcher's understanding of the emotional state and thought processes of the participants' spoken words (Oliver, Serovich and Mason, 2005).

Bracketing was practiced throughout the interview stage by way of memo writing, to examine the reflections that emerged for the researcher, and to observe and bracket where the research might be conscious of bias or preconceptions about the interview material.

The next section outlines the process of data analysis, including a step-by-step guide to how the data were collected and analysed using IPA.

Process of Data Analysis

Validity for analysis of the data was achieved by selecting a framework that best suited the aim and objectives of the study (Bazeley, 2013). The following section begins by outlining what analysis in IPA is, including the link to the interview procedures. The methods chosen for verification of the analysis are presented and credibility indicators outlined. Details of the IPA analysis process, and the development of the themes that emerged, including analysis tables presenting the codes and themes taken from participants' interview transcripts, are presented for clarification.

Analysis in IPA

The essence of analysis in IPA lies in the analytic focus, which in this thesis was directed towards participants' attempts to make sense of their experiences (Smith, Flowers and Larkin, 2009). IPA analysis is described as iterative and inductive. Iteration simply means repeating the same steps or sequence of steps that is carried out in the same manner and performed multiple times over. IPA analysis is inductive because analysis begins by observing what emerges from the iterative steps; beginning generally from a broad perspective and moving towards specificity to provide detailed examinations of the participants' personal lived experiences. Unlike deductive analysis that begins with a pre-existing theory, inductive analysis allows the theory to emerge through a process of iteration.

The primary concern of IPA analysis is to elicit as much detail and first-person accounts of the experiences and phenomena under investigation. Semi-structured interviews provide the greatest opportunity for in-depth, one-to-one interviews to achieve that aim (Smith, Flowers and Larkin (2009), and in this study, they allowed participants to engage in a 'conversational' dialogue, whilst enabling the researcher the space and flexibility to investigate any original or unexpected issues that might arise, in more detail.

IPA Analysis Process

This section provides details of the IPA analysis process. All four interviews were coded in accordance with the four steps outlined in Smith, Flowers and Larkin (2009), which refer to:

Step 1: Reading and re-reading.
Step 2: Initial noting.
Step 3: Developing emergent themes; and
Step 4: Searching for connections across emergent themes

Step 1: Reading

Four participants' transcripts were read and re-read, as suggested by Smith, Flowers and Larkin (2009), to become familiar with their words.

The transcripts were analysed manually, one at a time, beginning with the first interview and moving in consecutive order to the next by date.

Analysis began by listening to the recorded interview of the first transcript, connecting with the participant's voice, tone and emotion of responses given. This also aided manual analysis of the transcript, since the researcher could 'hear' the participant's voice as they read and re-read their transcript, ensuring that the participant remained the focus of the analysis. A record of the researcher's initial thoughts, recollections and observations were written separately in a notebook. This enabled the researcher to put these notes to one side temporarily, to remain focused on the data, but to return to at a later stage of the research. Repeated readings of the transcript enabled the researcher to become actively engaged with the data, noticing for example, when patterns in the transcript shifted from general to specific accounts.

Step 2: Initial Noting

A line-by-line inspection of the first transcript was completed, beginning by initially noting small observations, exploratory notes and queries on a hard copy. Small observations or points of interest were underlined on the interview transcript or written down in a notebook.

The three levels of analysis in Step 2 are descriptive, linguistic, and conceptual. Firstly, descriptive comments focus on the lived worlds and meanings of the participants. Secondly, linguistic codes focus on the language participants use to communicate their experiences. Thirdly, the researcher interprets the participants' experiences by way of abstract or conceptual analysis to engage at a deeper and more interpretive level. This process enabled the researcher to develop a familiarity with the transcript, to begin to identify the way in which the participants thought and spoke about and understood their experiences (Smith, Flowers and Larkin, 2009). The three

levels of analysis in Step 2 allowed the researcher to move beyond the descriptive and towards interpretation, to explore the meaning participants gave to aspects of their accounts.

Using a blue, red, and yellow highlighter pen respectively, descriptive notes were written in a separate notebook, noting key experiences of the participants' world with the blue pen. If pronoun, pauses, laughter, repetition, tone, or metaphor were key to that descriptive note, it would be underlined with a red pen to indicate a linguistic code. Conceptual comments concerning the participants' overarching understanding of their response to a question, and the researcher's reflections or interpretation of that response, were highlighted with the yellow highlighter pen. Table 2 illustrates an extract of IPA Step 2, which is in the participant's own words transcribed verbatim (and explains why sentences are not always complete), with initial analysis for P4, representing the three levels of analysis: descriptive, linguistic, and conceptual. Illustrations of Steps 2, 3 and 4 analysis are provided in Appendices 19a, 19b and 19c, respectively.

Table 2. Step 2: initial noting and extract from P4 transcript

Step 2: Initial Noting	
Original transcript	Exploratory comments
P: yeah ... um I it's interesting cos it was so hard to start talking about anything really so I was probably like spluttering around the first few sessions like no I'm not really gonna talk about anything really uncomfortable and like have you focused on the fact that the my sleeve of my coat is inside out on the hook or whatever you know like so it was probably quite hard to get me to start umm and I think that that was actually probably really good and I then was starting to talk about things but probably then talking about things is difficult and ... I dunno but it did it did change or it felt ... and whether that was because it would be interesting to actually look at the timeline which I kind of wish I had done before coming to see you sorry umm T: It's all right P: But whether that started to change after I was like I'm gonna move we've only got this number of sessions whether that then became ok well we need to push through some of this you know if this is gonna be helpful you need to talk about things I think but then I I don't know I volunteered talking like talking about the actual event but then was kind of annoyed by feeling	Clear sense of struggle to articulate difficult feelings of experience: especially self-preservation 'look at my coat' coping mechanism to distance self from the feelings. Repetition of hard: so hard quite hard, difficult: emphasising struggle of recalling the experience Strong sense of shift in participant's feelings about therapy Participant wanting some reassurance of a shift: wish I had got the timeline right, questions self. Did I want to leave therapy before or after the 'drug' suggestion? Seems important for the participant to *know*. Timeline just as the participant is moving through initial difficulties recalling the event. The therapist perhaps not gauging the timing for participant, introduces another aspect too early in the sessions?

like the idea of me being drugged was sort of put on me umm T: I feel that … P: err... and it changes the well there's a whole a whole other kettle of fish but you know I think that changed ...	Emergence of clarity around the shift: annoyed being drugged wasn't my idea but now that's *another* thing that adds to my difficulty in therapy. a whole other kettle of fish: participant finding therapy difficult enough, but now this new suggestion. Cannot manage both?

Step 3: Developing Emergent Themes

To reduce the volume of detail from the initial noting in Step 2, in beginning to identify emergent themes, the exploratory notes written by hand in the researcher's notebook were typed on to an A4 page and discrete chunks of transcript were typed out. For example, if P4 mentioned something linked to the impact of sexual assault in her life, then mentioned it again four pages later in the transcript, and then again on the final page, these three moments were typed together in a cluster. Reorganising the data in this way meant fragmenting the flow of the transcript narrative and there was a sense of something being lost and the data becoming unmanageable at this stage. However, at the end of this process, the researcher found several clusters or chunks of narrative that were inter-related, and themes began to emerge.

Emergent themes remained a reflection of the participants' original words and thoughts, but with the researcher's interpretation. Table 3 illustrates the emerging themes of IPA Step 3: developing emergent codes, again, using extracts from P4 transcription.

Table 3. Step 3: Developing emergent themes using an extract from P4 transcript with emergent codes

Step 3: Developing emergent themes		
Emergent themes	Original transcript	Exploratory comments
Coping as a process Disclosure is too hard	P: yeah ... um I it's interesting cos it was so hard to start talking about anything really so I was probably like spluttering around the first few sessions like no I'm not really gonna talk about anything really uncomfortable and like have you focused on the fact that the my sleeve of my coat is inside out on the hook or	Clear sense of struggle to articulate difficult feelings of experience: especially self-preservation 'look at my coat' coping mechanism to distance self from the feelings. Repetition of hard: so hard quite hard, difficult: emphasising struggle of recalling the experience

Sense of self and coping: I can't do this. Shock Annoyance: unanticipated Lack of control Fear Denial Pace of therapy is problematic, not attuned to participant?	whatever you know like so it was probably quite hard to get me to start umm and I think that that was actually probably really good and I then was starting to talk about things but probably then talking about things is difficult and ... I dunno but it did it did change or it felt ... and whether that was because it would be interesting to actually look at the timeline which I kind of wish I had done before coming to see you sorry umm T: It's all right P: But whether that started to change after I was like I'm gonna move we've only got this number of sessions whether that then became ok well we need to push through some of this you know if this is gonna be helpful you need to talk about things I think but then I I don't know I volunteered talking like talking about the actual event but then was kind of annoyed by feeling like the idea of me being drugged was sort of put on me umm T: I feel that … P: err... and it changes the well there's a whole a whole other kettle of fish but you know I think that changed ...	Strong sense of shift in participant's feelings about therapy Participant wanting some reassurance of a shift: wish I had got the timeline right, questions self. Did I want to leave therapy before or after the 'drug' suggestion? Seems important for the participant to *know*. Timeline just as the participant is moving through initial difficulties recalling the event. The therapist perhaps not gauging the timing for participant, introduces another aspect too early in the sessions? Emergence of clarity around the shift: annoyed being drugged wasn't my idea but now that's *another* thing that adds to my difficulty in therapy. a whole other kettle of fish: participant finding therapy difficult enough, but now this new suggestion. Cannot manage both?

Step 4: Searching for Connections Across Emergent Themes

The fourth step of analysis searched for specific connections between themes, which is referred to as abstraction and subsumption (Smith, Flowers and Larkin, 2009). Table 4 shows an illustration of the emerging themes for each participant for the subordinate theme of 'avoidance.

Table 4. Step 4: Searching for emergent codes across themes using extracts from P1, P2, P3 and P4

1. **Starting Therapy: Developing a relationship**	
Avoidance	
P1	Absolutely terrifying; start opening Pandora's Box; it's a very weird feeling
P2	I wanted someone else to take control; I wanted someone else to do everything
P3	Felt like a very long time dealing with things that were immediately affecting me
P4	Disclosure too hard; I can't do this; shock; lack of control; fear; denial

The process of identifying patterns between emergent themes is called abstraction, which maps similar themes together to create superordinate themes, providing an organising framework for the subordinate themes to come together. Table 5 illustrates abstraction of matching 'like with like' from P4's emerging themes (see Table 3), which can be grouped together to develop a superordinate theme.

Table 5. Step 4: abstraction for development of superordinate theme: extract from P4's transcript

Abstraction leading to the development of a superordinate theme
Emerging themes from P4's transcript **PTSD: Avoidance**
Coping Disclosure too hard I can't do this Shock Lack of control Fear Denial

Looking for patterns across participants

The result of this four-step process was to look for connections in the group and across all four participants. Table 5 shows how emerging themes were framed within a superordinate theme, illustrating the emerging themes for each participant for the subordinate theme of 'avoidance'.

IPA analysis prioritises an examination of convergent and divergent cases, revealing the way in which participants' perceptions of an experience are similar and different (Allan and Eatough, 2016). Table 6 shows an illustration of convergent and divergent emerging themes for the subordinate theme, 'Disengaging from therapy', within the superordinate theme of 'Client-expectancy effects'. Connections across P1 and P2 experiences were similar, but diverge from P3 and P4, who also shared a similar experience.

Table 6. Step 4: Example of convergent and divergent emergent theme connections across P1, P2, P3 and P4

2. Client-expectancy effects	
2.3 Disengaging from therapy	
P1	Now we are talking about this whole (name of place) did play a role in my choice to end counselling
P2	Four months later they phoned me […] and they said hi we've got a space for counselling and […] I just said its fine take my name off
P3	If you can tell me […] what the sort of plan is from here then I am not potentially coming back
P4	Yeah it was that easing out sort of thing […] it felt like too much

The analysis procedure was repeated exactly as outlined in the four steps above, for all four transcripts. Bracketing of the previous interview transcript was integrated to suppress leaking from the first, ensuring rigour and integrity for each individual transcript. Table 7 illustrates the master table of superordinate themes and related subordinate themes.

Table 7: Master table of superordinate themes and related subordinate themes

Superordinate themes	**Subordinate themes**
1. Starting therapy: Developing a relationship	1.1 Disclosure 1.2 Avoidance 1.3 Emotion Regulation and Resilience
2. Client-expectancy effects	2.1 Attunement 2.2 Client-perceived therapist effectiveness 2.3 Disengaging from therapy
3. Client-therapist relationship • bond of trust, caring, and respect. • agreement on the goals of therapy. • collaboration on the *work* or tasks of the treatment	3.1 Therapist effect on outcome 3.2 Facilitative conditions of therapy 3.3 The therapeutic relationship

The next section outlines the credibility and validity criteria for assessing the coding and analysis in this research study.

Verification of Analysis

Trustworthiness

Trustworthiness in qualitative research is dependent on the 'truth' in the findings. 'Truth' in reflexive research is not attainable (Silverman, 2016), at least not the absolute truth as is the goal of nomothetic, objectivist research. Silverman (2016) offers a realistic and credible notion of truth for the analysis of qualitative research, suggesting that truth claims are more placed upon a continuum, termed a "gradient of 'better' and 'worse'" (pp.141). In so doing, the scrutiny, positionality, and influence of the researcher on the practice of reflexivity, produces a more realistic and transparent analysis of the data than that of objectivist approaches, since all research involves limitations, contradictions and unreliable, illegible, or forgotten material. Furthermore, there can be more than one interpretation in idiographic approaches, since the language, metaphor, cross-checking, and vigilance throughout the analysis process were selected by the researcher. Reflexivity adds a further layer of validity as

detachment is honoured, and therefore the analysis procedure ensured ‘good-enough’ levels of truth claims to validate the findings (Silverman, 2016).

One of the ways to ensure the truth of the data is to test the credibility of the findings. The next section identifies three strategies that were incorporated in the analysis of the research data, to verify the accuracy of the findings and ensure rigor of process and interpretations.

Verification and Credibility Indicators

Paper Trail

A paper trail was kept throughout all stages of the analysis for auditing purposes (Guba, 1981, p. 87). The paper trail was partly electronic, but also partly pen and paper, as the four steps of analysis (Smith, Flowers and Larkin, 2009) required noting *on* the transcripts. Thus, the paper trail included a complete set of coded transcripts, an outline of the codes and interpretations, including record-keeping of the research questions, bracketing, notes of reasoning and decision-making behind the analysis choices, including reflexivity, as well as final definitions of analysis (Smith, Flowers and Larkin, 2009). In this way, if the analysis was replicated, a step-by-step procedure of how the data were gathered would be possible.

Member Checks

Guba (1981) outlined a framework for judging the trustworthiness of qualitative research, as well as criteria to determine the credibility of outcomes. Credibility in qualitative research is the equivalent of internal validity in quantitative research and is concerned. Credibility refers to the extent to which a research account is believable and appropriate, with reference given to the level of agreement between participants and researcher.

Participants were sent a copy of their interview transcript to ensure they were not being misrepresented. They could amend, delete, or give feedback on any aspect of their response. Three of the four participants did not require amendments, thereby

endorsing the truth of the narratives in the transcripts. The fourth participants, however, did not respond to the communication.

Thomas (2016) however, states that member checking, as a criterion for credibility in qualitative research, can be problematic, citing minimal changes in research findings and the potential for intruding on participants, which could be detrimental (especially for participants with PTSD). Despite this, the main purpose for member checking in this research study was to ensure the participants were being accurately represented, and as such, this information was clearly outlined in the participant consent form.

Transferability

Transferability involves the degree to which this research could be applied to different context and setting (Creswell and Creswell, 2018). Qualitative research does not generalise findings outside of those under the study, the value of which lies in the development of descriptions and themes only within the context of the study (Creswell and Creswell, 2018). In qualitative research, transferability does not involve broad claims, but rather invites readers of the research to make their own associations between elements of the research and their own experience. It is vital, therefore, that the phenomenon being studied allows the reader to have a proper understanding of it, thus providing them with evidence that the research study's findings could be applicable to other contexts, situations, times, and populations (Lincoln and Guba, 1985).

Conclusion

This chapter outlined how the methodological framework provided the most suitable approach to address the research question underpinning this study. It then described the method, including the ethical data collection process before concluding with full details of the data analysis. A constructivist Interpretative Phenomenology Analysis (IPA) methodology was used to develop and analyse what influences women who have experienced sexual assault to disengage from PTSD therapy earlier than planned. This leads to Chapter 4, the study's results, demonstrating the participants' experiences in their own language from transcription extracts of recorded interviews.

Chapter Four

Analysis

Overview

This chapter outlines the findings from the interpretative phenomenological analysis (IPA) exploring what influences women with PTSD from sexual assault to disengage from therapy. This chapter is divided into three sections, beginning with an overview of the participants, then moves on to present the findings of the IPA before summarising the main themes in the conclusion. Psychodynamic therapy (PDT) and defense mechanisms terms and definitions are provided in Appendix 2 and 3 respectively.

Participants

Four recorded interviews were completed at the WS head office, transcribed and then analysed using IPA. All four participants were previous clients of the WS who had received therapy for PTSD symptoms following sexual assault and had disengaged from therapy prior to completing the full complement of therapy sessions offered (Appendix 20 presents a summary of participant characteristics. Participant demographic data are illustrated in Table 8). Participants are referred to by pseudonyms and/or a number and all identifying information has been removed or changed. A simple reference number (Participant 1: P1) was given to each participant in order to protect their anonymity. Participant quotations are indicated in the text by their number, and line numbers that correspond to their transcript extract, included (P1, lines 10-20). (Appendix 20 provides a table of participant numbers, their corresponding pseudonym and the quotations outlined in the analysis).

Table 8: Illustrating participant demographic data

Participant number	Participant name	Age at time of interview	Number of sessions offered	Started therapy	Ended therapy	Number of sessions attended (approx.)	Interview date for project	Approximate timeline from therapy end date to project interview date
P1	Mira	27	16	12 06 2015	11 09 2015	9	21 01 2016	Five months
P2	Hailey	28	16	27 08 2015	03 09 2015 (ended by WS)	1	10 02 2016	Six months
P3	Alisa	25	16 (+10)	03 03 2016	08 09 2016	17	06 12 2016	Four months
P4	Helen	29	16	09 09 2016	11 11 2016	7	31 03 2017	Five months

Superordinate Themes and Connecting Subordinate Themes

Taken from across the four participants, the application of the Smith, Flowers and Larkin (2009) IPA analysis revealed three superordinate themes, which were: (1) Starting therapy: Developing a relationship, (2) Client-Expectancy Effects and (3) Client-Therapist Relationship. Each of the superordinate themes had three subordinate themes, which are presented in turn using a selection of quotations. Diagrams 4, 5 and 6 demonstrate the structural relations between the superordinate and subordinate themes (Appendix 19c outlines in full the superordinate themes, subordinate themes, and the structural relationship between them).

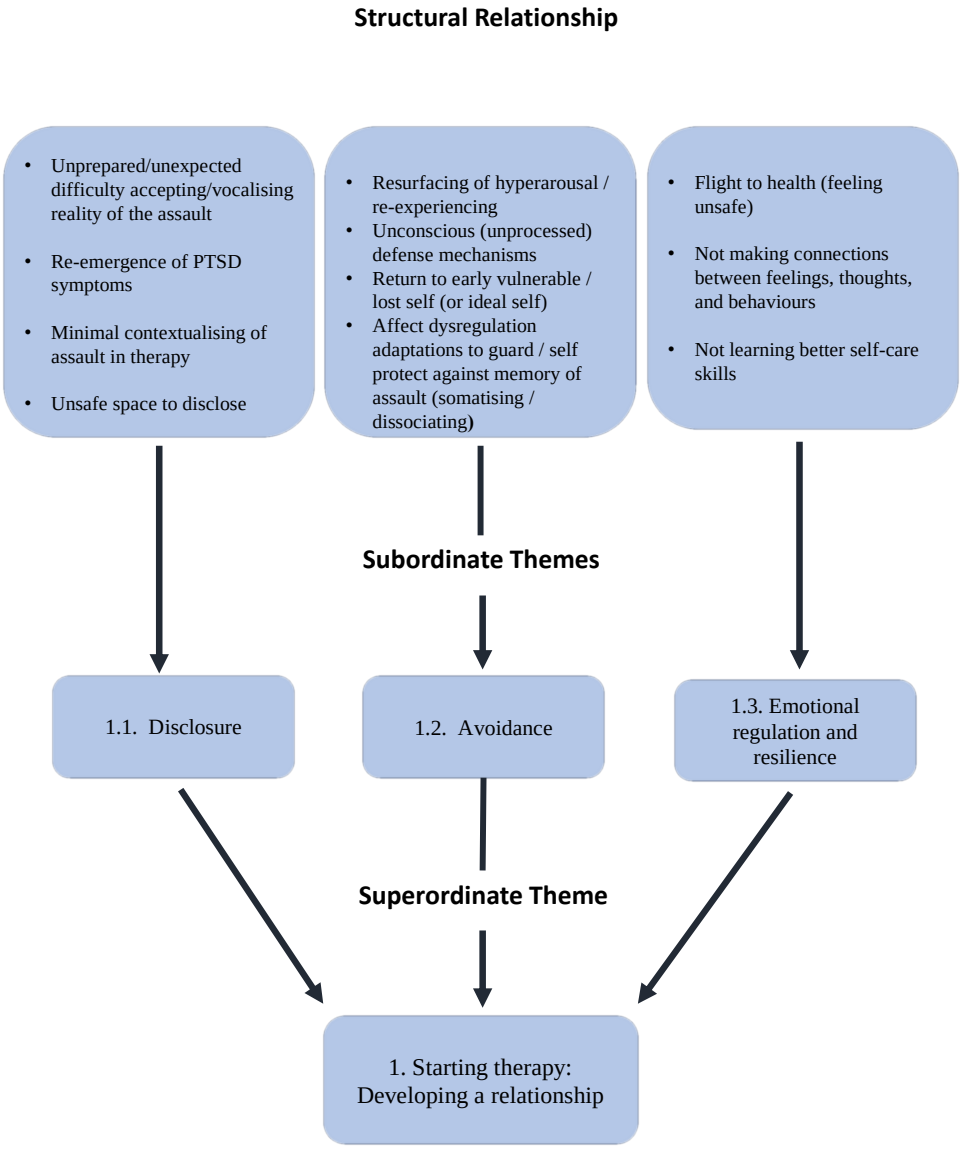


Diagram 4 demonstrating the structural relations between superordinate theme 1 and the subordinate themes.

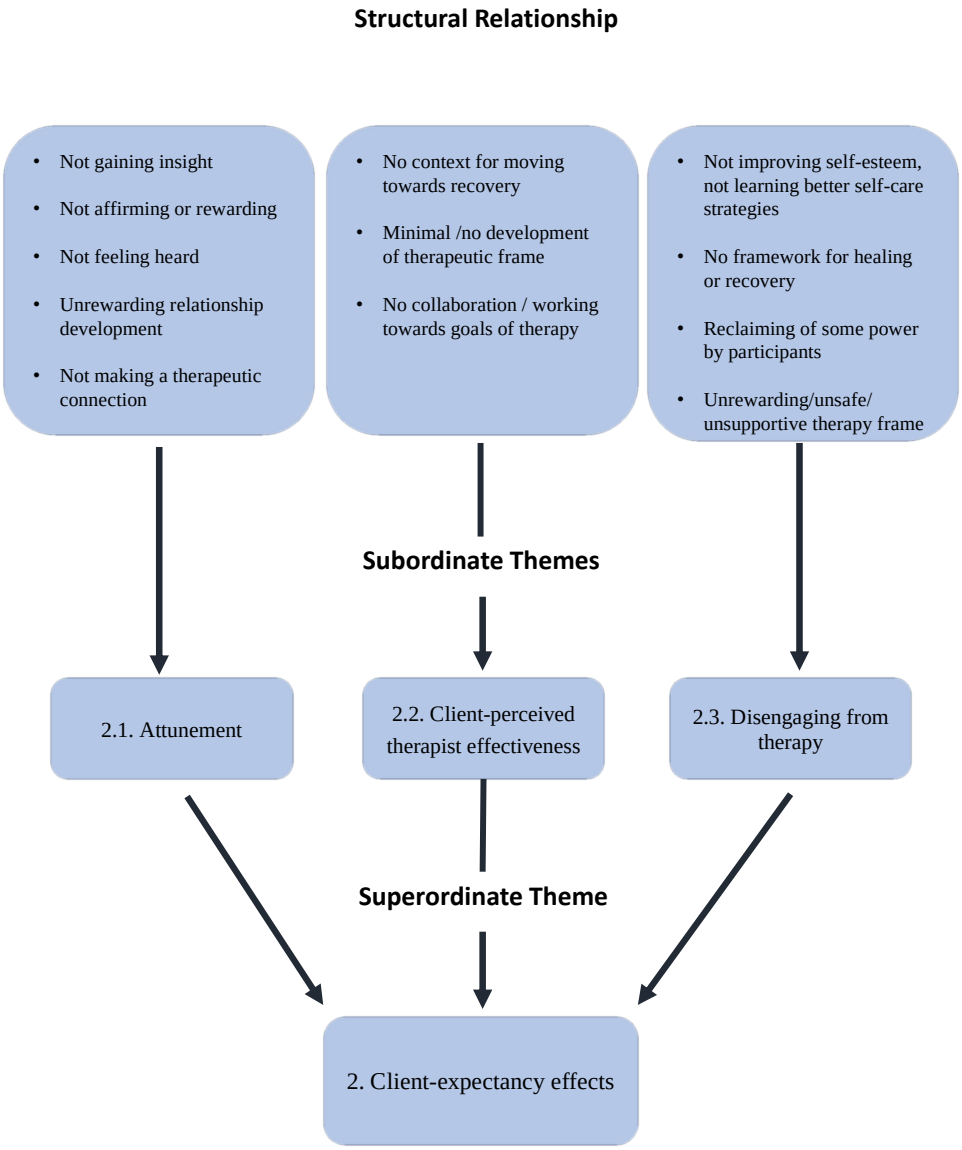


Diagram 5 demonstrating the structural relations between superordinate theme 2 and the subordinate themes.

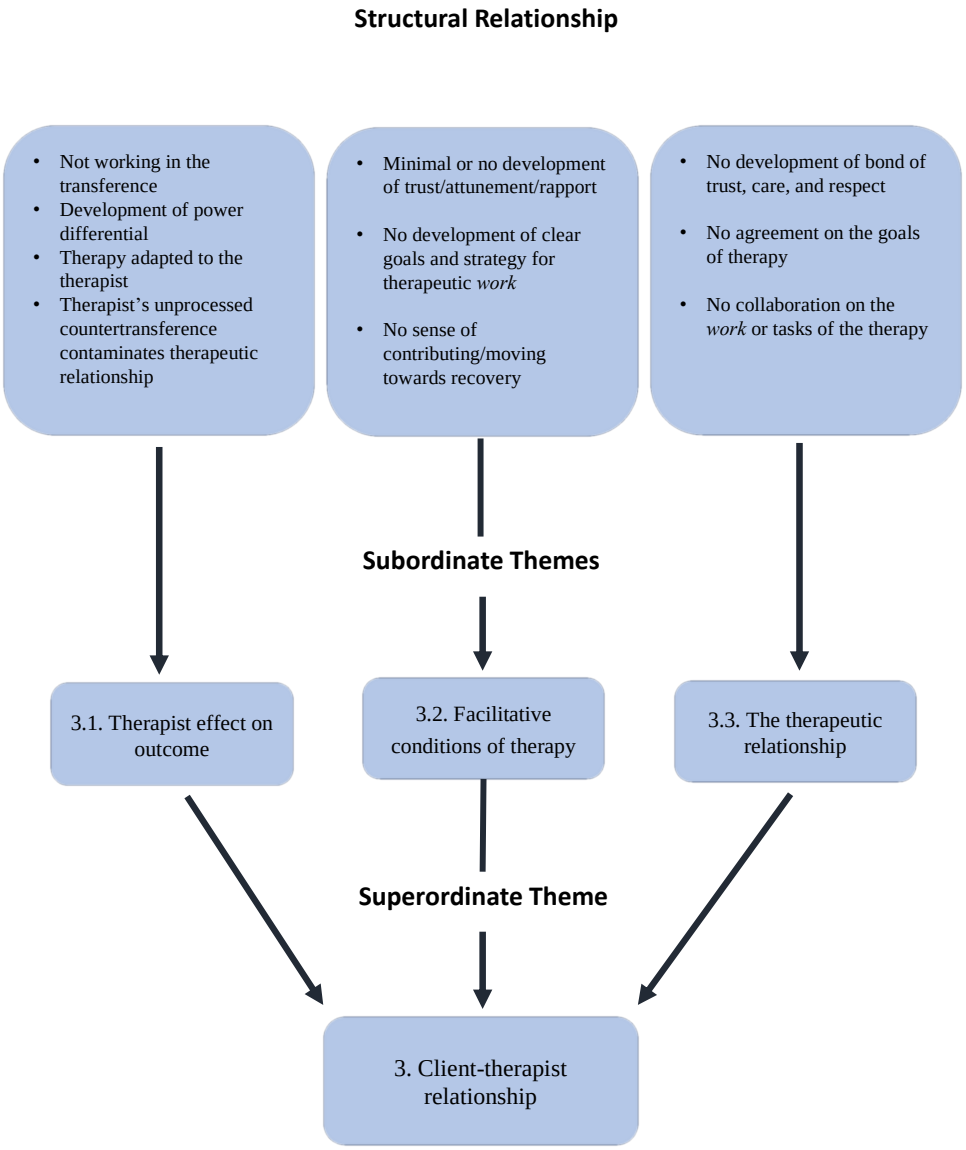
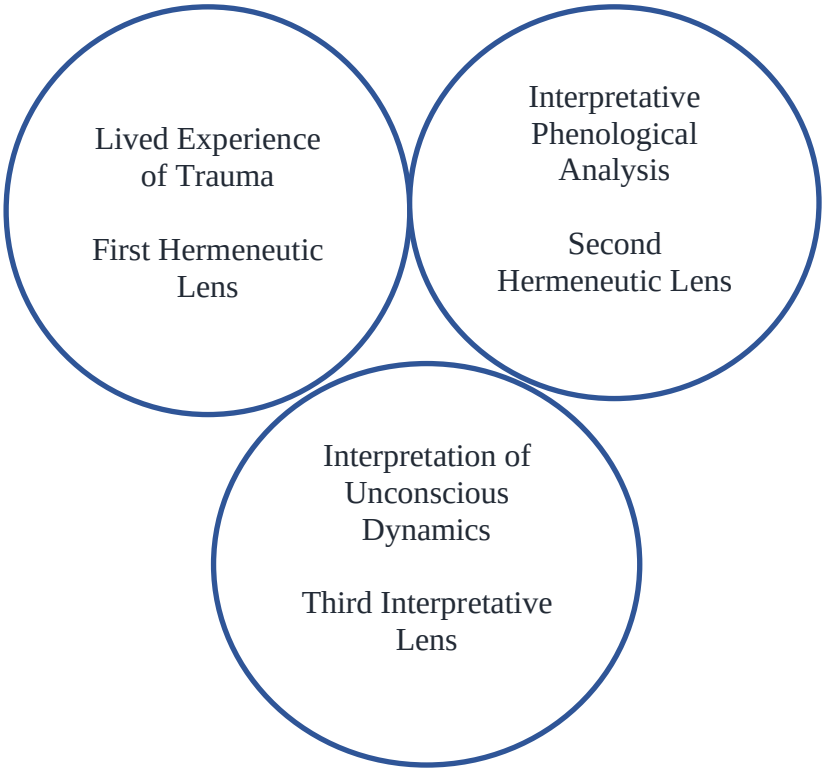


Diagram 6 demonstrating the structural relations between superordinate theme 3 and the subordinate themes.

In order to illuminate the perceptions and lived experiences of participants, the author introduced a third lens: a triadic hermeneutic, to IPA analysis in the form of psychodynamic interpretation. Hermeneutics was discussed at length in the Methodology Chapter, 3, but it is helpful to return briefly to hermeneutics in order to argue the researcher's introduction of a third lens in the analysis process (Published: 6/17/2015, no date). The researcher engaged in double hermeneutics in the analysis process in attempting to understand and develop knowledge of the participants reality by interpreting the contextual meaning of the lived experience, the conscious meaning. IPA is essentially based upon consciousness, the essence of the phenomena and the lived experience. PDT has a separate ontological and epistemological platform from IPT which is informed by the unconscious as opposed to IPA's emphasis on consciousness. This triple hermeneutic, encompassing the double hermeneutics *and* a third component in PDT and unconscious process, allowed for greater depth of illumination, making it possible to bring together the participants lived experience of trauma in the therapy room. IPA (conscious) interpretations *and* PDT (unconscious) interpretations, allowed for a deeper, and multi-faceted mining of the lived experience of sexual assault-PTSD.

Diagram 7. Visual aid showing triadic lens of the lived experience combining phenomenological inquiry and psychodynamic interpretation.



The raw material is presented in detail in the next section, using direct quotes from the participants interviews, which will enable the reader to distinguish between the researcher's interpretations and the introduction of a third lens (unconscious) interpretation.

Findings

In order to detail the intensity, richness and strengths of the participants' experiences, quotations have been selected that capture both their convergence and divergence, as well as their shared and individual experiences.

The themes are reported in chronological order, starting at superordinate theme 1 and its associated subordinate themes, 1:1 and 1:2, proceeding to the final superordinate theme 3, and its associated subordinate themes.

Superordinate Theme 1: Starting Therapy: Developing A Relationship

The early stages of trauma therapy focus on building rapport, trust and safety in order for participants to feel safe enough to begin disclosure. The communication skills of the therapist play a vital role in this initial disclosure stage towards building a relationship with the participant.

Subordinate Theme 1.1: Disclosure

Disclosure in trauma therapy is the process whereby a client shares information about the impact of the assault experience with the therapist. There is a multiplicity of complexity around disclosure for clients when they begin trauma therapy for sexual assault. Often present is an inner conflict between the wish to deny the traumatic experience and the wish to articulate it. This conflict is often, but not always, due to the client's fear of being engulfed by a repetition (re-experiencing) of the feelings of the assault experience.

From the following quotations, it was possible to get a sense from the participants accounts that beginning therapy was not what they had expected and suggests that initial difficulty and complexity of disclosure communications of the assault was unanticipated, apparent in this quotation from P1.

> "*Yeah I mean like aside from the fact it was very... the whole thing was very weird you know it's very weird to go two years after to a place and suddenly sort of start opening Pandora's box a very weird feeling I wouldn't say it was like traumatising I didn't you know leave the place and say I'm going to cry I was just like it was kind of a weird thing ..." (P1, lines 115-118)*

P1 used the word "*weird*" (lines, 115, 116, 117, 118) four times in this quotation, giving clear indication that talking about the assault was more difficult than she had anticipated. P1 mentioned "*suddenly start opening Pandora's box"* (line, 116), yet the only thing that might have been sudden was talking aloud about the assault, which might suggest that the assault memory had been long held at bay. An important sense of time is apparent, relating to P1's repressed memory of the assault that was avoided until she began therapy. Her use of the Pandora's box idiom strongly implies her fear of uncovering the long-held hidden evils of sexual assault emerging into consciousness, and a clear indication of some anticipation of uncovering those memories.

A similar interpretation could be made from the following quotation from P4, in a comparable experience with P1, in the unexpected intensity of the first time, she voiced the experience of her memory of the assault to the therapist.

> *"Err yes I don't it's funny actually I don't think I remember things particularly clearly it was all quite intense but I found it pretty intense and not particularly containing afterwards I was I rang my friend crying in the street which is something I would never do ..." (P4, lines 21-23)*

P4 used the word “intense” (line, 21) twice in this quotation, indicating that talking about the assault experience was more difficult than she had anticipated. P4 also describes being triggered when disclosing the assault experience in the assessment, following many years of non-disclosure. The complexity of P4 feeling not “*contained*” (line, 21) may have foreshadowed her unpreparedness for the emotional rigours of disclosure, as the assessment forced the memories of her assault into consciousness. The quotation also infers P4’s sense of losing herself, or her expected self, because she would never cry in the street (line, 22), possibly indicating her struggle to re-stabilise after the assessment.

In the following extracts from P2 and P3, some parallels can be drawn in their experiences of long-held memories concerning the difficulty to manage the disclosure of sexual assault:

> *“And I felt quite like [be]cause at that point like I had no sort of apart from obviously family and friends well I didn’t really tell my family but my friends like I didn’t have any like I felt quite alone [be]cause I didn’t really have that like support.” (P2, lines 67-68)*

There is some suggestion from P2’s quotation that, though she had a support network of family and friends, she did not have *that* support, implying a lack of safety and of uncertainty of receiving possible negative reactions from them. Negative social reactions may have reinforced, for example, some of the feelings that P2 may have struggled with, such as shame or self-blame or feeling revictimized. The silence of P2’s aloneness, so often the language of revictimisation in the aftermath of sexual assault, is inferred in her struggle to disclose to family and friends. Perhaps as a means of coping with repressed memories, P2 experienced feelings of isolation because she did not have the right support in place to begin to disclose the traumatic account in safety, and so withdrew from those around her, possibly due to a sense of powerlessness and an ongoing sense of fear and vulnerability, as well as an inability to recognise those she felt safe with and trusted. Feelings of shame related to sexual assault can often accompany survivors’ isolation and withdrawal, which may have contributed to P2’s experience of isolation.

Possible negative reactions from social support can also be inferred from P3's quotation, where disclosure to so-called 'experts' also have the potential to be particularly harmful. The ability to recognise or allow herself to trust, has possibly been compromised post-assault, suggested in her quotation:

> *"Yeah I think umm I felt that so it was things that happened a very long time ago and it's quite a long and detailed and complicated story so I thought the best thing is just to explain it all give the broad picture of everything that happened and then we can start dealing with it umm and I think I felt quite frustrated in that I was essentially just trying to explain everything but felt that there was lots of umm lots of impediments to that in that umm understandably my counsellor kept asking me how I felt but I kind of wanted to express what had happened so that my counsellor would then have a better understanding of what am I feeling and why and how to deal with that umm which I think I expressed at some point so the story takes a while to explain and the sessions always seemed very short even if just an hour or a bit less umm and so I felt it might take a session or two before we can actually make any progress then because there were lots of certain interruptions in that I think I felt like I spent the first three or four or more sessions even just giving the basics and then I think by the time I left counselling my counsellor had very little idea of umm all of the things I experienced and wanted to address" (P3, lines 51-63)*

The impact of long-held, undisclosed memories of the assault, over time, was apparent in P3's account. When P3 described feeling imposed on by her therapist's interruptions may imply a lack of attunement in the very early disclosure sessions of therapy. P3 may have felt this as being silenced by her therapist but may have felt powerless to address this, since her therapist did not (or would not) hear her disclosures. The overt shift in P3's focus onto the therapist's behaviour suggested from her quotation, seems to have become central to the communication in her therapy, and the difficulties around disclosure of her sexual assault experience became secondary in the therapeutic encounter, possibly as a way for P3 to protect herself from assault memories and to exert some power over her therapist's potential to

emotionally harm her. Such an exchange has the potential to develop into a power-dyad in the therapeutic relationship.

Two further interpretations implicit in the development of P3's early disclosure in therapy might be lack of attunement and parallel process. For example, the therapist interruption of P3 during the important disclosure stage, may suggest a lack of attunement to actively listen to the P3's account. This may suggest the therapist's unconscious resistance to hearing P3's disclosure of the assault and anxiety to take in the material that P3 wanted to bring. Therapists' can become susceptible to vicarious trauma from repeated exposure to difficult or aversive traumatic material, like sexual assault. The therapist's emotional responses to P3, such as attunement and active listening may have become disrupted during the integral disclosure sessions. Disruption in the therapist's emotional responses to P3 might potentially be due to parallel process, in which the therapist may have experienced something similar to P3's disclosure. Possible unconscious identification with the client's material could be suggested in the therapist's defensive stance. Parallel process can occur for many reasons, for example, if the therapist was unconscious of her own identification with P3's material in the transference and countertransference process. The skill of the therapist to attune may have been compromised as a result, and she may have unconsciously defended against hearing P3's disclosure.

A further possible interpretation regarding disclosure concerns the inference of mentalisation in P3's quotation. Mentalisation is the ability to understand one's own and others' mental states, and to comprehend one's own and others' intentions and affects. It is possible that due to the interruptions, failure of the therapist to develop an interpersonal inventory from P3's conveyed information during the early disclosure sessions, for example, patterns of behaviour in her relationships, evaluating her responses from discussions about her current relationship in the developing relationship with the therapist, may have shaped the nascent therapeutic relationship, and unconsciously (or consciously) entered into a non-mentalising encounter. A teleological mode of non-mentalisation may have over-strained the therapy dyad further, where the goals and purposes of therapy for P3 are sought through objective, accessible, measurable facts. It can be inferred that P3 became over-focused on the therapist hearing out the full history of her assault experience, communicating to the

therapist that she might be in a familiar or established patterns of rigid views of communication.

Subordinate Theme 1.2 Avoidance

Therapy for sexual assault PTSD, encourages clients to begin talking about the impact of the assault, which they often (but not always) want to avoid. In essence, clients are asked to approach the very situations they fear the most; a secure therapeutic relationship must be at the core of this type of disclosure. Some therapeutic strategies to accomplish a strong therapeutic relationship might focus on building trust between the therapist and client, since factors associated with PTSD, such as hyperarousal and avoidance, can create significant distress for the participant in establishing trust or psychological safety.

Possibly, as a means of coping, or to manage difficult feelings during disclosure in therapy, the following quotation suggested that P1 might infer her psychological avoidance and self-soothing, in anticipation of painful memories. Evasive measures are inferred, possibly as a means to manage hyperarousal:

> *"For me it's absolutely terrifying I mean it's like it gets to different people have different reactions to it like I never been good at like I mean I'm not it's like you get very used to sort of keep it for yourself yeah if* that makes *sense because you can't you get used to getting sure." (P1, lines 331 – 333)*

P1 was clearly unprepared for how terrifying therapy was going to be and may have become used to denying, minimising, and repressing 'it' to herself, possibly to avoid the terrifying feelings that being in therapy may engender. Similar defense mechanisms are suggested in the following quotation from P4:

> *"yeah ... um I it's interesting cos it was so hard to start talking about anything really so I was probably like spluttering around the first few sessions like no I'm not really gonna talk about anything really uncomfortable and like have you focussed on the fact that the my sleeve of*

my coat is inside out on the hook or whatever you know like so it was probably quite hard to get me to start ..." (P4, lines 339-342)

P4, similarly, struggled to begin an account of her experience, and possibly experienced hyperarousal and vigilance in anticipation of disclosing in therapy. P4, instead, avoids, evades, and shifts her focus away from therapy and on to her coat, possibly to self-soothe as an unconscious psychological strategy used to protect her from anxiety arising from unacceptable thoughts or feelings.

P1 and P4's extracts diverge from P2 and P3's experiences, where it was suggested that P2 and P3, at least on the surface, appeared to want to begin talking about their experience. In the following quotation from P2, it is inferred that she is struggling with a disruptive anxiety or hyperaroused states, that she grappling to neutralise, resist or defend against:

"[...] I just I think also by that point because it had gone on for so long and I'd been waiting and waiting and just reliving this again and again and again I got to the point where I was like I just wanna find someone ... "(P2, lines 176-179)

The sense of urgency inferred in P2's quotations may imply her struggle with intrusive or recurring memories of the assault, and her coping mechanisms and defenses may have become compromised prior to starting therapy. It might also be linked to P2 seeking support after repressing and avoiding these responses about the assault for a very long time.

Defense mechanism of avoidance, in the form of somatic symptoms, were suggested in the following quotation from P3:

"[...] the way that I felt that was having the most umm severe impact on me at the time was through issues with eating which I'd mentioned in my assessment and which I'd made clear and yet we never talked about that or sort of ways that I might deal with that ..." (P3, lines 109-112)

P3's eating difficulties could possibly be interpreted as somatising difficult to manage PTSD symptoms. A significant focus was placed on her physical symptoms in the use of her body, pre and post the assault, possibly as a vehicle for communicating the impact of the traumatic experience, which was not voiced in therapy. Instead, P3 focused her attention on the therapist, which, in effect, enabled her to avoid disclosure of the assault in therapy. P3 unconsciously avoided a narrative of the assault in therapy, perhaps shifting her focus on to the therapist, as a coping mechanism that might be a repeating pattern of avoidance and control. It could be suggested that avoidant defensive patterns may be triggered for P3 when hyperaroused states threaten to undermine her unconscious illusion of control.

Subordinate Theme 1.3 Emotion Regulation and Resilience

In order for the participants to begin to experience some resolution of the traumatic assault, they needed to be able to begin to face and overcome disruptive traumatic memories with the therapist, in therapy. Developing emotional regulation, that is, adapting to and regulating emotional states can develop sufficient resilience for working through trauma memories. Successful resolution is entirely dependent on whether a client has developed sufficient emotional self-regulation and resilience to safely navigate their traumatic experience in therapy.

In the following quotation from P1, when she states that on the one hand, she was aware that she was not healed, and on the other, she did not need therapy anymore, may suggest ambivalence in an approach-avoidance conflict within herself, about being faced with her own vulnerable emotional states, possibly heightened by working through the assault experience. P1 may have struggled to regulate such emotional states, suggesting that resilience was fragile, which could have impacted the relationship with her therapist.

> *"So in a sense it's like I never came to a session to counselling and said I'm fine I'm healed and I don't need sessions anymore that you know a*

process but it wasn't at one point I felt I didn't need it anymore the process I was going through it was more what I was doing myself than what I was actually doing in the session and going losing a whole day for that." (P1, lines 392 – 395)

P1 is possibly suggesting that she could heal herself, without the therapist's intervention. She implied that she has learned enough about how therapy worked and was reluctant to take a day off from work for something that she '*didn't need*' (line, 393) anymore, when she can do it herself. Unconsciously, however, this could also be interpreted as P1's avoidance to remain in therapy and the possibility of re-experiencing painful trauma memories that might reflect a lack of resilience and emotional regulation to endure further sessions.

A similar interpretation is implied in the following quotation from P2, in which she recounts the memory of her emotional states post-assault, and how she was able to get in touch with painful trauma states retrospectively.

"[...] if I had therapy a good therapy person two weeks or three weeks after it happened to me I would have been a disaster like I don't think it would been helpful to me at all I think I was like I was like I couldn't even like think straight I could I needed someone to do the therapy for me I think I needed support of some sort I'm not sure what but I don't know if therapy but I don't if I'd refer ... I'm reluctant but I don't know why it's strange I don't really know why I'm reluctant." (P2, lines 514-519)

This quotation suggested that P2 recognised the impact of the assault on her psychological and emotional wellbeing in the development of her destabilisation prior to therapy, when she talked about the "disaster" (line, 515) of assault. After her experience with the WS however, and with some reflection, she seemed reluctant to recommend therapy, implying that something of the experience with therapy felt unsafe. Therapeutic interventions for sexual assault trauma such as stabilising, regulating, and affirming emotional states were outside of her experience because her therapy sessions were ended abruptly after the first session. In retelling her therapy experience retrospectively, suggests a new awareness and recognition of her lack of

emotional regulation and vulnerability in the quality of her ambivalence and possible hostility aimed at the WS that she was able to recognise later.

Ambivalence and hostility might also be suggested in the following quotation from P3.

> *"[...] I was just overly optimistic about it and sort of thought well it's so convenient so near my work this should be good this should be helpful and sort of was trying to will it to be helpful and attended for so long but I didn't feel like I was making any progress or like it was useful to me in any way." (P3, lines 68-71)*

P3 attended the greatest number of sessions of the participants (17 sessions), despite her awareness that she was not making progress and therapy was not useful "*in any way*" (line, 71). It can be inferred that P3 rationalised about the venue being convenient and the therapy for PTSD being what she wanted, however there was a sense that regulation and resilience work had neither begun nor developed. The overt shift of P3's focus onto the therapist's lack of skills to help her, may have indicated a rigid or inflexible compulsion to repeat, as a means to avoid and defend against experiencing the traumatic memories of the assault. Possibly, P3 could not allow herself to be vulnerable, and to allow the therapeutic relationship to provide protection and buffer psychological and emotional disruption inevitable in the retelling of the traumatic account, and to aid in the development of her resilience and regulation. There does not seem to be suggestion of healthy adaptive functioning development during P3's therapy, which is key to the development of resilience. There is a suggestion that P3's therapist may not have been working in the transference and may not have recognised P3's difficulties, gauged in her defenses that arose in the transference. The therapist may not have identified that P3 was struggling with regulating emotionally in therapy.

Another interpretation for her underdevelopment of resilience and regulation in P3's therapy is the possibility that in the absence of mentalisation, development of emotional regulation may have been undermined, such that instead of P3 being encouraged to think about her feelings in therapy, they may have become

enacted instead. For example, P3 states in this extract that she attended therapy for so long, but she didn't feel like she was making any progress or that it was useful to her in any way. When such enactments are not made conscious, a pattern of nonverbal interactional behaviour could have developed between P3 and her therapist, and loaded with unconscious meaning for both. The therapeutic relationship can become compromised beyond repair under such conditions.

The following quotation from P4's description of her therapy experience, possibly in an attempt to avoid the traumatic memories of the assault, suggests that she struggled to develop and regulate her emotional states sufficiently to remain in therapy.

> *"I did the whole massive like routine shut the ... oh actually [name of city] is way too stressful for me right now actually I'm gonna move to the [name of city]." (P4, lines 137-138)*

P4 was aware that she was running away from therapy, despite rationalising that at the time of her therapy she needed to leave the city because it was too stressful for her. This quotation suggests that P4 *was* aware of her difficulties and struggled to adapt and develop resilience and regulation around the traumatic assault memories in therapy. At some level, she was conscious that this, in part at least, was the reason that she disengaged from therapy. The primary factor in the development of resilience is in supportive relationships that can create trust and provide models for support and reassurance, such as in the therapeutic relationship. Therefore, it could also be implied from P4's quotation that something of those crucial factors were missing in the therapeutic relationship.

Superordinate Theme 2 - Client Expectancy Effects

In therapy, both the therapist and the client form expectations about the behaviours and experiences that will define the therapy. These expectations can impact the therapeutic relationship, the course of therapy, and the therapy outcomes. Therapists' and clients' expectations are important determinants of their behaviour in therapy.

Subordinate Theme 2.1 – Attunement

Clients' expectations of therapy influence their decision to enter into and remain in therapy. Clients approach therapy with expectancies regarding the nature of therapy and the roles that they and their therapist assume, which can regulate, adjust, and modulate the effectiveness of therapy.

A traumatic event can have a deleterious effect on all survivors' relationships. Survivors' ability to trust is often compromised when viewed through a PTSD lens. Trauma symptoms like hyperarousal can be trigged in expectation of perceived danger, betrayal, or potential harm within new and old relationships. Survivors may often feel vulnerable and confused about what and who is safe, and therefore it may be difficult to trust. The moderating influence of therapeutic attunement is important in trauma therapy since it is an integral stage to improving the quality of the participant's interpersonal relationships, mirrored by their therapist, to develop a sense of a safe, trusting relationship. It is inferred from the following quotations that the participants felt misunderstood by their therapists' and were unable to understand and assimilate their therapists' interventions. From the following quotation, it was suggested that P1's therapy was impacted by a lack of attunement and interpersonal relatedness by her therapist:

> *"I think that we were incredibly different as people and I was very practical I'm very practical I need to do things I need to have the feeling I'm actually doing something I'm not contemplative and I cannot sit and observe I can't just ... I'm not even sure if it's possible or not but like I need as a person I need to sit down and feel like I'm actually doing something to solve the issue which sometimes not just sometimes like talking about how you feel about things doesn't give me that and as much as I had to learn how to talk about feelings once I started doing it I guess I hoped that we would do something different." (P1, lines 399 – 406)*

It is suggested that P1 may have shifted to intellectualising her feelings in therapy, to seek safety from a therapy relationship that threatened to touch on terrifying or

uncomfortable material, for example P1 described herself as a "practical" (line, 400) and "doing" (line, 401) individual. From her quotation it can be inferred that issues relating to her therapist are around attunement or rapport, evident when P1 stated that she wished her therapist would talk about something other than her feelings. It is possible to infer that intellectualising had become established in her communication, possibly to avoid confronting traumatic material, or possibly due to her therapist's lack of attunement to address such communications.

P3, similarly, intellectualised as "thinking" and someone who liked to "analyse" and "rationalise" (line, 369). P3's experience of her therapist has many parallels with P1's. In the following quotation from P3, she stated that her therapist's personality was too different to her own, like "sand and stone" (line, 375), citing the therapist's divergent approach and her personality as the difficulty she experienced in therapy.

> *"Umm I think so I'm very intuitive so I like to [...] I think as well I'm I'm very thinking as opposed to feeling so I like to analyse and rationalise umm I mean probably too much I am aware of this so I I I think my counsellor was more feeling than me and that is fine and actually I think useful because I think the issue was that I am often too thinking about err important emotional or significant emotional issues and I was sort of hoping that counselling would be a good framework in which to address that it's unfortunate because the way the framework they were using to view the whole issue was so divergent that there was no yeah I think the combination of sand and stone both being different just meant there wasn't any chance." (P3, lines 366-375)*

It was possible that P3 was unconsciously intellectualising in therapy, as a defense mechanism against the traumatic material, and possibly in an attempt to redirect attention away from affective experiences she redirects them into thought processes that are emotionally safer and detached. Potentially, the therapist might have recognised and made conscious the client's defenses of the trauma material, however, in the absence of the development of attunement in establishing a therapeutic bond early in the therapy process, may have contributed to difficulties in gauging and

addressing P3's defenses of traumatic affect. Intellectualisation can potentially lead to mis-attunements, which may have impacted P3's continued engagement in therapy.

Difficulty around issues of trust in therapy and possible undeveloped therapeutic attunement was also suggested in the following quotation from P2:

> *[...] I always thought that someone I paid I was always worried and this was before ... this is really early on I was really worried that I would go somewhere and they'd tell me that there's something cos I wanted someone to tell me there was something wrong with me cos I felt like then I could label things and then it was like a thing and I was really worried someone would tell me that there's something wrong with me so then I'd get a really pessimistic view of mine that's what I was really worried about (P2, lines 539-544)*

P2 described a pessimistic view of private therapists with whom she felt unable to enter in to a trusting relationship post-assault. It could be inferred from P2's quotation that a diagnosis would give her something concrete to hold on to, and the reassurance to enter into a therapeutic relationship that allowed for the illusion of some control of the therapist's focus around a diagnosis, and thus the relationship. Potentially, this might be linked to her struggle to judge and gauge which relationships were safe, due in part to an impaired ability to trust anyone, post assault, and possibly due to her experience in therapy and the lack of rapport that she recognised in the first (and only) encounter with her therapist at the WS.

In the following quotation from P4, she seemed to have decided that the therapy model and or the therapeutic relationship did not work for her, and though it was unclear whether P4 had spoken to her therapist about her approach, it might be inferred from this quote that her decision was made unilaterally.

> *"Yeah but I also feel like I I had maybe decided that it was not the right approach for me or something I don't know but I don't think it is I still would definitely say I'd still recommend and I still think it's very useful I*

just dunno if that relationship was as good as it could have been or was the right one ... yeah does that make sense?" (P4, lines 439-442)

It could be suggested that P4 was reassured by having a tangible reason, or something that she could label, as a reason to disengage from therapy. A teleological mode of non-mentalisation could have also entered P4's therapy, in which concrete, tangible, objective facts buoyed her confidence and confirmed her decision to disengage. A teleological stance might have enabled P4 to deny or minimise her avoidance of the struggle to communicate difficult trauma material in therapy. Moreover, a continued teleological stance in therapy can impair attunement in the therapeutic relationship and was unlikely to promote any therapeutic change or wellbeing.

Subordinate Theme 2.2 – Client-Perceived Therapist Effectiveness

Client-perceived therapist effectiveness is defined as the client's belief that their therapy will result in beneficial change and/or reduced symptoms.

Perceived therapist effectiveness was strongly linked to all of the participants' therapy experience. The following quotations from P1 suggested that she did not like her therapist's reaction when she cried in therapy.

"[...] once I opened I cried in session like I have never cried in front of anyone after I cried in a session it was really emotional I was like can we start doing something in a way and I guess that in the last moment she would have been more positive proactive almost I kind of had the feeling that she was just going to sit there and wait for me to tell her what happened last week or what I didn't do since last week and how that made me feel and part of the session was always the same." (P1, lines 406 – 411)

P1 was evidently disappointed by what she described as the mechanics of therapy; the repetition of certain aspects of therapy that were unchanging. P1 described a session in which she cried, indicated by "once" (line, 406), exposing her vulnerability in a way that she had not done in therapy before. This could suggest that P1's therapist was not adapting her approach or working with the material P1's was bringing because "*part of the session was always the same*" (lines, 410-411). It might also have been P1's avoidance to talk about her feelings in a desire for her therapist to be more proactive, however there is a sense from this extract of P1 wanting more from her therapist. Reflecting on the transference, the client may have been relaying emotions and unmet needs associated with people from her past, and the repeated denial in the present relationship with a detached or unavailable therapist, in a familiar pattern of interpersonal difficulties, was possibly engendered. There is a suggestion that the maintenance of the therapeutic relationship were strictly modelled within the boundaries of the therapist's approach, and was not adapted to meet P1's needs.

The following quote from P4 suggests that she was unprepared when her therapist starting to explore with her about the details of her assault, which may have angered her, possibly leading to a mortal rupture in the therapeutic relationship.

> *"[...] some of the things that were said I remember getting quite annoyed about umm a feeling that that an idea of it put in my head about alcohol and drugs was the thing like was I I was drugged or you were drugged or that's how I remember it being said like do you think that or it sounds like you were drugged or something like that but it not being my idea and that really annoying me like." (P4, lines 175-179)*

It was quite a significant interpretation made by the therapist, in offering P4 a new framework for understanding the assault. Perhaps due to a lack of stabilisation, and/or a lack of attunement, the therapist unknowingly undermined a fragile therapeutic relationship and assumed rather than gauged P4's readiness for the interpretation. This possibly destabilised P4 when she was unable to process a new perspective to work through with the therapist. In fact, it could be suggested that the therapist's interpretation created hostility for P4 because her therapist did not allow her to arrive

at this new awareness herself, and as a consequence, P4 was forced to consider an alternative interpretation that she was emotionally unprepared for.

From P2's quotations it was evident that she remembered having a better rapport with the therapist for her assessment, than the therapist allocated to her at the start of her therapy. Some ambivalence can be inferred in P3's expressing '*I didn't think she was really special*" (line, 176). It was also possible that P2 may have felt more attuned to the first therapist. However, it may also suggest some latent hostility towards the WS, in P2 redressing a power differential retrospectively, when considering her lack of power over the therapist's decision to withdraw her therapy.

> *"[...] I remember feeling like she was quite different like I think I preferred the person who did my assessment she felt quite I don't know now but I didn't not like her like I would have been happy to have gone back to her I didn't feel any I didn't think she was something like ... I wasn't ... I didn't think she was really special or like sort of thing cos it was yeah (P2, lines 173-176)*

In the following quotation, P3 described her attempts to directly communicate her frustration in therapy, to her therapist.

> *"[...] you know this isn't working between us you know communication isn't really working very well and I was trying to be as diplomatic as about it as possible but you know she said to me at some point that essentially she felt that I just thought that she wasn't very bright and not very competent umm." (P3, lines 270-273)*

There is a strong sense of hostility, and unprocessed countertransference in which it can be suggested that the therapist has become defended, perceiving P3 as criticising and undermining, possibly in her transference and in her overt expressions of dissatisfaction. There is also evidence of a power-dyad that has been allowed to progress in this therapy relationship. P3 and her therapist have possibly moved in to a defensive (and perhaps a repeating and familiar frustrating relationship pattern for P3) psychological conflict over who was holding the power. It was apparent from this

quotation that P3 was not working through her trauma experience with the therapist, and possibly implied the therapist was almost certainly unconscious of her countertransference processes.

Subordinate Theme 2.3 – Disengaging from Therapy

Disengaging from therapy is defined as a client ending their therapy without the therapists' agreement, and before completing 16 therapy sessions outlined in the therapy contract.

It can be suggested in P1's statement that the "balance thing" (line, 500) implies that if she felt that therapy *was* going somewhere, it may have promoted her engagement in further sessions. However, the following quote could equally be interpreted as an unconscious defense mechanism of a flight into health. There is suggestion that P1 may have become hyper-aroused possibly due to the therapist's continual focus on her feelings. P1 might have become defended and avoidant; that is, ending therapy would also end the focus on her traumatic experience.

> *"The whole truth was that it was kind of a balance thing it was you know I mean I feel like we weren't going anywhere." (P1, lines 500-501)*

A more meaningful interpretation, however, suggests that P1 may have perceived the effectiveness of therapy as lacking; that some components within the therapeutic relationship, such as attunement, were unfelt, and without discernible benefits, evident in P1 stating "I feel like we weren't going anywhere" (line 201) was perhaps, inferring a feeling of stagnation or stuckness that prompted her to end therapy.

In this next quotation from P2, she is remembering and reporting the details of her therapist's decision to end her therapy after the first session. Inferred in this quotation is a sense that P2 retrospectively minimised and rationalised the impact that her therapist's decision had on her. However, it is possible that in revisiting her

experience of therapy, allowed P2 some expression of hostility to surface, implied in P2's quotation:

> *"I think I was away for three weeks so I don't think it was like huge but they emailed me back and said unfortunately we can't keep the things for you you'll have to go back on the waiting list which … … […] and I got back at the end of September and so they'd kind of I think I got emails." (P2, lines 133-136)*

It might be inferred that P2 felt that when she returned from her break, the therapist would make a discretionary exception for her therapy contract, however, communication from her therapist confirmed that her therapy was ended. P2 may have taken this decision personally and felt victimised by the decision, in her stating, "*I don't think it was like huge*" (line, 133), suggesting that P2 may have felt rejected and was repressing some anger or hostility about a perceived injustice or unfairness of treatment. Clients with sexual assault trauma can sometimes re-enact defensive roles, such as perpetrator (the therapist) and victim (P2), which is possibly being replayed here. It might be inferred from P2's quotation that an ongoing pattern of interpersonal fear and betrayal from her therapy experience, and a perceived injury may have lingered.

The potential development of a power differential in the therapeutic relationship is implied in the following quotation from P3 therapy description.

> *"I went to one session and I said I don't think this is working for these reasons [...] so you know if you can tell me you think if I've made progress for these reasons you know reasons I don't understand umm or what the sort of plan is from here then I am not potentially coming back umm I think she said well you know I can think about that and get back to you next session or something something like that so I felt that I wasn't really presented with any reason to come back to complete the sessions so I emailed her afterwards and said that I didn't think it would be useful for me to come back." (P3, lines 213-221)*

When P3 was denied a review of her therapy progress by her therapist, it may have unconsciously conveyed a power differential in the therapy-dyad. One interpretation could be the therapist's hostility in her countertransference, perhaps due to being perceived as unskilled in P3's transference. Though couched in a reasonable request, P3 was requesting concrete evidence of her progress by intimating to the therapist her felt sense of a lack of progress. It is possible that the therapist did not recognise or did not acknowledge P3's shift into a non-mentalising stance, when she might have focused on bringing P3's attention back to a mentalising approach, re-establishing a curious stance about P3's thoughts, feelings, and intentions for her therapy, and engaging in re-stimulating communication that may have promoted attunement. It is very possible that denial of the progress report was a significant enough unrepaired rupture for P3 not to return to therapy. Reparation of therapy ruptures need to involve the actions of both P3 *and* her therapist, however it is the therapist's responsibility to recognise and respond to ruptures non-defensively. For example, the therapist might have reflected on P3's interpersonal skills or deficits revealed in the unconscious dynamics that were at play between herself and P3. Once this was made conscious, there was a possibility of therapy moving forward again, where both therapist and P3 developed a new awareness of P3's coping strategies and her mentalising inner world.

Parallels of unrepaired therapeutic rupture can be drawn from P4's quotation, though it can be suggested that P4 had more awareness of her internal struggle when she acknowledges that she was finding therapy too stressful and remembering the assault had become too triggering. This awareness was apparent when she said, "*it felt like too much*" (lines, 150-151).

> *"Yeah it was that easing out sort of thing yes I think so probably an element of that yeah I think there were a lots things going on at that time [...] but lots of things were going on and it felt like too much but also I fell in love so that was why I eased out of that well yeah at the time I positive about leaving [name of city]." (P4, lines 148-152)*

“Easing out” (line, 148) is an interesting way for P4 to describe ending therapy, implying moving slowly and carefully out of something. It conjures up a feeling of P4 treading carefully or trying not to make a bad situation worse possibly as a way of minimising the emotional impact for her (and perhaps soothing her therapist’s feelings) as much as possible. It might also suggest P4’s desire to create distance from scary assault memories and move towards a loving relationship and a chance at ‘normality’.

Superordinate Theme 3: Client-Therapist Relationship

Therapist effects can be defined as the systematic effects of therapists on client outcomes beyond that of the therapists’ modality, technique, or number of years’ experience. Some therapy effects include, but are not limited to, influences such as the quality of the bond in the therapeutic relationship, level of agreement regarding the goals and focus of therapy, and the therapists’ ability to recognise and repair ruptures in the therapy relationship. The following quotations from the participants explored and interpreted some of the effects in their therapy experiences.

Subordinate Theme 3.1 Therapist Effect On Outcome

From P1’s quotation, there is suggestion that she was trying to create distance in the therapist relationship and move into the safety of the practical. It is also possible that P1 was unable to communicate her feelings of being overwhelmed in therapy, that resulted in her therapist continuing to move forward in the same way and with the same approach, possibly without acknowledging the developing rupture in the relationship. It might suggest a lack of attunement by the therapist, to recognise P1’s distancing affect, or potentially an inability for the therapist to adapt her approach to more attune to P1’s therapy needs. It is apparent that the therapist did not find a shared language to allow P1’s transference to be processed. The following extract clearly illustrated the therapist’s impact in the therapeutic relationship that silenced P1, and possibly, in an unprocessed transference projection, aroused the therapist’s

anxiety of feeling deskilled in her countertransference. In sensing P1 wanting something more, or something different from her, might have unconsciously aroused anxiety in the therapist's confidence to adjust and modify her approach.

> *"It's not about I mean I'm not a psychologist so it's really hard to say I mean even just writing down things putting it on the table some physical things to do would have completely changed my attitude you know what I mean." (P1, lines 416 – 418)*

A further interpretation could be the therapist's maintenance of a power imbalance in the relationship, by not empowering P1 to communicate negative evaluative observations about her therapy.

There is suggestion in P2's quotation, when she implied something of the power dyad, describing feeling oppressed by the people in power. P2 used the word "downtrodden" because she clearly felt badly treated and rejected by the therapist who retracted her therapy sessions.

> *"I ... I think by that point I was just so like kind of it felt like a bit downtrodden from the whole experience it was actually other people like a friend of mine who was more appalled by it than me like she was like [...] how can they you know she was much more like ... why?" (P2, lines 190-193)*

Potentially, P2 could have been distancing herself from the power imbalance by deferring her outrage to a friend to voice. Being unable to express her own anger suggests that she was unable acknowledge her powerlessness or vulnerability because that might have brought her dangerously close to similar feelings of powerlessness, post-assault.

Apparent in P3's quotation is her preoccupation with the maintenance and management of her own therapy and over-focus on the therapist, rather than working on the issues that brought her to therapy. It is inferred that P3 believed this created the difficulty between herself and her therapist, stating they were "completely opposite"

(line, 362). Possibly, the emergence of a negative countertransference as a response to P3's transference, may have developed in this therapy. For example, if the therapist feels the client's transference as negating or resisting her attempts to help, may trigger the therapist's unresolved anxieties and insecurities, questioning her ability to take care of others sufficiently, or fears of being under-skilled or inefficient. Coming to understand and audit these countertransference responses may have enabled the therapist to attune and identify with some of the emotions underlying much of P3's negative transference. However, if the therapist continued to feel triggered by the client's transference, this can shut down therapeutic engagement instead of moving P3 forward. P3 may have felt the therapist defending against uncomfortable feelings that P3 engendered, in a negative countertransference. P3 may have sensed the therapist's defensiveness in her discomfort, and unconsciously empowered P3. P3 experienced her therapist as frustrating, punishing, inefficient and rejecting. It is the therapist's task to recognise and process her countertransference material and to remain neutral in working towards reparation of the relationship, returning the projected material safely back to the participant to make conscious those relationship patterns with other, significant people in her life, for example, her mother.

> *"[...] and I felt that my counsellor and I were just clearly completely opposite and I could see there is conflict areas of our understanding each other." (P3, lines 362-364)*

P3 recognised her therapist's hostility (in the development of a negative transference and countertransference dyad). Perhaps P3, though powerless to change the relationship, due to the therapist's unconscious unworking through of her countertransference, aided P3's continual avoidance of her traumatic experience.

> *"... ... ... there was definitely an atmosphere of hostility at the end." (P3, line 456)*

Without the therapist's intervention or reparation, however, it is suggested that the hostile atmosphere remained throughout P3's therapy experience. What is interesting, however, is that P3 remained for so long with this awareness.

There was a sense of ambivalence in P4‘s decision to end therapy. A sense perhaps of her being conflicted, and in a state of hyperarousal, triggered in her early therapy sessions, which perhaps remained throughout the remainder of her therapy. What P4 heard her therapist say and the therapist’s intention, might have become lost in P4’s heightened or anxious response. For example, P4 might have heard her therapist through a hyper-aroused lens, in which she was criticised or judged by the therapist. The “*choo choo choo*” (line, 406) might be an indication of P4 psychologically distancing and soothing of re-remembering the therapist’s interpretation that she was trying to stifle:

> *“[...] I felt I was feeling kind of like that somehow I was like retraumatising myself and that was unethical and the whole like the drug thing there choo choo choo were things that like stand out as [...] I didn’t like them it but not that the whole thing was unhelpful.” (P4, lines 404-407)*

“But not that the whole thing was unhelpful” (lines, 406-407) suggested something of her acknowledging her part in the therapy process and recognising some of the benefits.

Subordinate Theme 3. 2 Facilitative Conditions of Therapy

Facilitating conditions are the conditions or attitude of the therapist that support and advance the therapeutic relationship and contribute to positive outcomes in psychotherapy. Supportive conditions are essential for building a secure bond in the therapeutic relationship. In the stages model for trauma therapy,[44] for example, the therapist actively develops stability, security, and safety in the relationship to allow a client to express emotions that cultivate a secure base for the client to speak in a judgement-free, therapeutic setting.

When asked a question about communicating her therapy concerns to her therapist, P1 responded with a very thoughtful answer about trust:

[44]Three stages of recovery in therapy (Herman, 1992)

> *"[...] it's a big step to trust someone it's a huge step to go in a place and trust that person that you're going to talk about ... that like the idea of questioning like going to a place and question that and you do it actively and you do it in a positive way I don't think I mean I think it's a huge step because you have to question the trust that you had to create without destroying it by turning it into a different direction and that's like that requires a [inaudible]." (P1, lines 477-481)*

This response suggested that P1 may not have developed enough trust in her therapist "*to talk about ... that"* (line, 478). P1 may have believed that communicating her feelings about the therapy experience would destroy the trust in the therapy relationship, even though trust is the building framework in which the therapy relationship facilitates the foundations for clients to voice all of their concerns. This extract suggested that P1 needed to tread carefully to maintain the relationship with her therapist, otherwise her therapist/therapy would be destroyed by her negative evaluations. It implied that the level of trust in the therapeutic relationship was very fragile.

When P2 states you can't "*cut me off*" (lines, 220-221) when her therapist ended her therapy after one session, perhaps suggested something of her feeling of powerlessness in the face of a powerful organisation that she was unable to challenge. P2 introduced the notion of the NHS as an example of a fair system of healthcare, perhaps, that remains impartial. There is an implication from this extract that P2 believed there was some injustice about her therapist's decision, that perhaps it was not impartial. It feels like P2 has taken the decision personally.

> *"[...] like I don't feel like we have it's not really my right to get counselling here that's how I kind of felt I was like it would be amazing if I could and it would help me a lot but it's not I don't have like it's sounds weird like if it was like the NHS I'd be like no this is my right you can't just cut me off kind of thing." (P2, lines 218-221)*

The sense of P2's powerlessness from this extract, and also that she was required to simply accept the decision, allowed her to get in touch with her anger retrospectively

in her statement "*no this is my right*" (line, 220), which was potentially aimed at the WS. A possible interpretation to understand P2's retrospective anger could be in a re-enactment resulting from psychological vulnerabilities and defensive strategies that are often characteristic of sexual assault survivors. For example, P2 may have unconsciously recreated her feelings of powerlessness about the sexual assault experience that was being felt in that moment and projected on to a powerful organisation that was exerting control over her, leaving her feeling once again, powerless and victimised. Potentially, it could also be interpreted as an unconscious repetition of a painful experience belonging to her past, that had the added secondary benefit of allowing some of her anger about being sexually assaulted to dissipate, in that moment.

In this extract from P3, it seemed apparent that there was little collaboration in the therapeutic relationship:

> *"I think it was just for me it was very nebulous I just didn't really have any idea where we were heading or what the aim was or what the goal was." (P3, lines 145-146)*

P3's focus on the deficient development of the facilitative conditions by her therapist could be interpreted as a powerful projection. The continued focus on her therapist's experience does not prompt P3's disengagement from therapy, which raises the question as to why P3 remained in a dissatisfying and unhelpful therapy for so long. Perhaps, for P3, unconsciously holding on to power, in light of her therapist's defects, may have assuaged her anxieties about letting go of her intellectual defense and allowing herself to be vulnerable. This may possibly have been too closely linked to feelings of powerlessness in P3's other relationships, outside of the therapy room, which might have been unconsciously played out in her therapy relationship.

From this extract, it is implied that P4 was feeling a sense of persecution in feeling judged by her therapist's interpretation about P4 continuing in her field of work:

> *"[...] I'd I think she said to me that it was it was sort of dangerous what I was doing like working in ... you know talking about like sort of*

retraumatising myself or something umm I can't remember the term like [...] Something like that umm and then I felt like I'm doing something really unethical kind of thing like by continuing to work like and obviously it's a lot how I interpreted it what I heard and what she actually said whatever but I." (P4, lines 287-294)

The therapist's interpretation might have been introduced too early in the sessions and may not have been aligned to P4's preparedness to hear it. This could have aroused mistrust or unpredictability in her therapist's skills to facilitate the sessions appropriately in gauging P4's level of resilience. Another explanation might be that the therapist's ill-timed interpretation undermined the facilitative conditions of P4's therapy, and instead of the therapist's interpretation enhancing the therapeutic relationship, it may instead have countered a successful therapy outcome. Implied in P4's quotation is a pejorative, and punishing interpretation, when P4 described feeling judged and criticised by her therapist's interpretation. P4's hearing this may have triggered a feeling of victimisation. If the therapist was not working in the transference, she may not have been conscious of P4's re-victimising and self-judging in the transference. It could also be inferred that the therapist's unconscious countertransference may have reinforced P4's feelings of victimisation, and unconsciously facilitated and colluded in an unsuccessful therapy outcome.

Subordinate Theme 3.3 The Therapeutic relationship

In the following extract from P1's account of therapy, she was describing her confusion about her therapist's lack of warmth in her final therapy session, when she ended therapy.

"I guess because it's kind of its such a weird relationship it's not like ... you have this person that you don't know at all that knows a lot about you and you talk with her but you're not like into a ... start believing that you have a relationship with her but then when that breaks because you say you're not going to do therapy anymore the whole spell breaks and you're like this is a stranger again like [...] I was like should I hug her and like she didn't do anything I was kind of waiting for her to give me like ...

because I was like she didn't do something like she would not shake my hand or give me her hand or something so that I can say ok I'll shake hands and she didn't and so we had no physical contact at all." (P1, lines 559-569)

There is a strong sense that P1 grappled to understand the status of her relationship with her therapist once she decided to end therapy. That her decision might not be welcome, resisted, or inappropriately managed by her therapist did not seem to occur to her, but P1 felt her therapist's hostility at the end of therapy. P1's struggle to comprehend the therapeutic rupture in the relationship is felt as her therapist's psychological and emotional detachment. P1 distances herself from the memory, possibly as a protective coping mechanism, by stating in the third person, "*you start believing that you have a relationship, but that breaks when you decide to leave*" (line, 561), suggesting P1's attempts to come to terms with the therapist's distancing or hostility is due to the therapist no longer being constrained by the boundaries of the therapeutic contract. Object relations theory offered an alternative interpretation in the context of the internal object, that is the therapist, as the significant other with whom P1 related. The term 'object' can refer to significant others, usually the mother or primary caregiver, though it can also refer to symbolic parts or fragments of a person, such as the mother's breast. In object relations the infant navigates both pain and pleasure from the good breast and the bad breast. The good breast is the channel for sustenance, nourishment, satisfaction, and wellbeing; the bad breast is unpredictable, painful, denying and panic inducing. An object relations interpretation of the ending of therapy could also be P1's attempt to defend against possible anxiety of ending therapy (bad breast), and so symbolically killed the good breast (object/therapist) in order to make the ending tolerable.

A further interpretation regarding P1's ending of therapy in sensing the therapist's unfriendliness or unwillingness to ease the closing of her therapy, might be explained in the therapist's countertransference. When the therapist did not (or would not) acknowledge the ending, it is a possible that she took the news of the ending personally, and unconsciously (or not), felt that her abilities were undermined, or, that P1 had displayed some power in her decision to end therapy. The therapist might have unconsciously punished P1 to redress a perceived power imbalance in the therapeutic

relationship. It might also be inferred from P1's quotation that remembering her final session resonated confusion and discomfort, possibly due to the rupture remaining unprocessed and unrepaired. An appropriate ending would have allowed P1 to reflect on and work through the therapy process with her therapist. Instead, P1's quotation implies confusion, anxiety and perhaps self-blame. If the therapist felt the ending as a personal failure, she may have projected this on to P1 and without successful resolution, the possible rupture in the therapeutic relationship remained unrepaired for P1, long after she ended therapy.

The sense of frustration in P3's account of her therapy relationship is recounted in the following quotation:

> *"Well I think I was trying to umm separate the feelings that I was having towards the counselling from the feelings that I was having towards the issues I was talking about" (P3, lines 234-235)*

There is strong suggestion that P3 continued to focus on her therapist's behaviour that might have been repeating or re-enacting an old object relationship (possibly her mother), to get it right this time. Internal representations of models from our childhood can often get played out, unconsciously, in our adult relationships and in therapy. Whilst P3 remained preoccupied with the process of therapy and in particular her therapists' behaviour, she was perhaps able to avoid working on the difficulties which took her to therapy in the first place. Without her therapist's intervention to make this apparent, P3 experienced a wholly unsatisfactory therapy.

In the following extract from P4, she implied that her therapist experienced some difficulty about her working in a similar profession, which undermined her experience in therapy:

> *"[...] like I started to feel as if the fact that I was working in [name of organisation] and you know was a thing it was somehow it was a thing it was affecting the way things were talked about or the way and then and then near the end it being said like oh I pushed you harder or something and I was like oh I'm not sure I feel like that's appropriate oh like I find it*

quite hard to talk about things anyway let alone so but I don't know how you know maybe all of that is something I was bringing." (P4, lines 328-333)

There were two notable elements to P4's experience of therapy from this extract. The first appeared to be the avoidance or discomfort of her therapist about P4 working in a similar field. The therapist's avoidance of directly addressing this in therapy suggested that it caused all subsequent interactions between herself and P4 to be slanted, as they carefully navigated not mentioning what they were both thinking. As such, it became impossible to have an authentic, meaningful dialogue. Secondly, and related to the first, was the therapist's assumption of P4's resilience for the trauma work. This lack of attunement created a fracture in the therapeutic relationship that remained unworked through by the therapist. P4 suggests that her therapist's knowledge of her profession made her judgemental and affected her therapy experience by 'pushing her harder'. This implies that her therapist was unable to separate the vulnerable client from the professional client. However, it might also suggest P4's struggle to enter a vulnerable state with her therapist (relinquishing her power), as well as her struggle to let go of her professional self (relinquish control) to begin to trust her therapist. When P4 stated that it might be something that she "*was bringing*", perhaps implies some awareness of her avoidance to engage in therapy too.

Conclusion

This chapter has provided an analysis from participant contributions through the model of IPA, relating to the early disengagement of four participants from PTSD therapy at the WS. Each theme element was substantiated with quotes from the participants' transcripts. From the themes presented and conceptualised within a psychodynamic psychotherapeutic stance, it is possible to see a clear pattern in the development of a complex therapeutic relationship that has emerged in the voice of four women's experiences of therapy for sexual assault PTSD.

The structural relations between the superordinate and subordinate themes illustrated in diagrams 4, 5 and 6 are helpful in revealing minimal development of the

therapeutic frame in the early disclosure therapy sessions that subsequently created an unstable and insecure therapeutic space. The therapeutic frame provides the context for the therapeutic work, within which are contained the boundaries for the work. Therapy is solely dependent on therapist's ability to set the framework to enable clients a safe enough space to begin the work. From the very first encounter the therapist sets the frame for optimal development of trust, care, respect; agreement on clients' goals of therapy; and collaboration on the work or tasks of therapy, which is maintained and reviewed in recognition of the emergence of clients' stabilisation, regulation, resilience, and insight and awareness: all of which is contained within the safety of the developing therapeutic relationship. All of therapy hinges on the therapist's skill to develop the therapeutic frame.

From the analysis and demonstrated in diagrams 4, 5 and 6, it is evident that the participants struggle to articulate a language of the assault experience, which the therapist might expect, but which the participants were unprepared for. Lack of context, or minimal contextualising of the assault, developed an unexpected and unsafe space for the participants who were unable to tolerate the disturbance and dysregulation engendered by memories of the assault. It is possible that this destabilising effect in the participants early disclosure therapy sessions generated a too fragile frame, and an undeveloped therapeutic relationship finally undermined the therapy. One can also see from the diagrams a clear trajectory of the participants re-emergence of PTSD symptoms in their inability to tolerate negative emotional states, and so avoid, defend, and dissociate. The participants become lost and confused within a vague, amorphous therapy model and a framework without context. They may have begun to recognise that they were not moving towards recovery, due to minimal noticeable benefits, and so the participants began to withdraw and disengage.

Having provided the background and the key themes from the analysis process, the next chapter will present an in-depth discussion of the analysis and the implications of these findings for support and interventions for women who have disengaged from sexual assault PTSD therapy.

Chapter Five
Discussion

Chapter Overview

In this chapter, the findings presented in the results section will be discussed in reference to the literature review, with the aim to answer the questions posed by this research. Other, selective literature is introduced for the first time in this chapter, that connects with the work, and which is particularly resonant to new and unanticipated developments from the results section. The discussion will draw on the participants' shared accounts of three factors that they perceived to have influenced their decision to disengage from therapy. These participant experiences are covered across three sections: [1] Starting therapy: Developing a relationship, [2] Client-expectancy effects, and [3], the client-therapist relationship. Each section will explore more deeply the layers, which reflect the level of complexity involved in the process of the participants' decisions to disengage.[45] TFT and non-TFT therapy terms and definitions, including a brief description, is provided in Appendix 1. Psychodynamic therapy (PDT) and defence mechanism terms and definitions are provided in Appendix 2 and 3, respectively.

Taken together, the three sections provide detailed insight into the nature of those influences that resulted in the participants disengaging from sexual assault PTSD therapy.

[45] Illustrated in Chapter Three, Table 7.

Starting Therapy: Developing A Relationship

The experiences shared by the participants in this study show clearly that therapeutic process factors, such as the therapeutic relationship, played a key role in their treatment for post-traumatic stress disorder (PTSD), which is consistent with existing theory and literature (Paivio and Pascual-Leone, 2010). It is recognised in literature and in practice that this relationship provides a foundation for clients to feel safe and supported in the difficult process of re-experiencing traumatic events and serves as a reparative model for previously failed attachment relationships. The skills and techniques that therapists bring to build a healthy therapeutic relationship, are determinant of successful reduction and resolution of trauma symptoms (Paivio and Pascual-Leone, 2010). These include building trust and mutual respect, without which, a meaningful therapeutic relationship in therapy cannot take place (Keller, Zoellner and Feeny, 2010**)**. The strength of the bond in establishing trust and respect, culminates in a rapport that is developed between client and therapist which is sustained over the course of treatment **(**Keller, Zoellner and Feeny, 2010). Through this rapport, the therapist is able to act as a facilitator for the client, so that the client is able to achieve their goals.

One means of determining whether the developing therapeutic relationship is safe is a measure of the extent to which a client discloses (Farber and Metzger, 2009). Client disclosure[46] in therapy is a marker[47] from which the therapist develops an interpersonally safe therapeutic environment (Farber and Metzger, 2009). Research studies have focused on key issues related to client disclosure in therapy, including what clients do and do not reveal to their therapist, client-therapist factors affecting

[46] Client disclosure: the therapist facilitates the client's ability to reveal thoughts and feelings without censorship (Farber, 2003, p. 590).

[47] Markers signal to the therapist to pay attention and to intervene. For example, verbal and non-verbal micro-process markers signal for a therapist's attention and response. These range from: subtle bodily movements, such as pulling back, voice tightening, or a slight shrug, to grand gestures, such as broadly sweeping an arm, turning away, or a chopping motion with the hand. Physiological signs of arousal include deep sighs or sudden gasps, and blocking behaviours, such as facial muscles tightening or going blank. Markers are communications conveying information and determining the mutual regulation between therapist and client through conversational sequences. These communications become the foundation for building the therapeutic relationship, and influence client-therapist exchanges from the initial stages of their encounter (Brubacher, 2012; Del Giacco, Anguera and Salcuni, 2020).

client disclosure, such as the development of safety and trust in the therapeutic relationship, and the nature of the relationship between disclosure and therapeutic outcomes (Farber, 2003). Client disclosure is explored further in the next section.

Disclosure

Within this study, it was possible to discern from all participants' accounts that disclosure of the impact and experience of sexual assault in therapy sessions was provoking a resurgence of traumatic memories. The retelling of the event gave rise to the necessity to seek safety in building trust in the therapeutic relationship: a central feature of the therapeutic relationship that engenders emotional containment. The participants shared several important facets that undermined the management of containment in the initial disclosure therapy sessions, developing a too-fragile trust within the participant and therapist relationship. The participants' disclosure sessions explored themes of intensity and strangeness of therapy (Mira, Helen) when sharing accounts of their experiences with their therapist, and when hearing their own voices recounting previously unspoken thoughts and feelings (Mira). There were also themes of frustration and isolation (Alisa, Hailey), held in, or long-repressed memories of their experience (Mira, Hailey, Alisa, Helen), and finding the foundations in the frame of therapy unsafe or lacking containment, extending to within the organisation. A facilitating therapist will take in a client's anxiety, sadness and pain and remain contained and safe, creating a safe environment that models and reflects healthy self-regulation. If the therapist is uncontained, the boundary in the therapy room will be breached by the therapist's own subjective material (Finlay, 2016). Should this occur, they are unlikely to hear (take in) the client's material and return it in a safe and adapted form to the client. It is impossible for therapists to work with clients' emotional processes if they themselves are unaware of their own.

The matter of disclosure in the initial stages of therapy, as demonstrated across all participants' accounts, set the tone for the entirety of their therapy. Participants shared their assumptions that disclosure would help them to feel better, however, this was undermined when relating the experience that may have been previously repressed or denied. Should disclosure engender negative consequences in the initial sessions of therapy, such as feelings of blame and shame, or a perceived inappropriate response

from their therapist, treatment management may be hampered by evoking feelings of not being safe and/or of re-traumatisation.[48] Disclosure requires a facilitating environment in which therapist responses can begin to reaffirm self-worth and improve psychological and physical wellbeing (Thurrock Joint Strategic Needs Assessment, 2019).

Disclosures in therapy do not always produce supportive responses or the desired response for participants. Such experiences can have a detrimental impact on trust, early relationship development or prompt avoidance of further therapy sessions. When describing their very early sessions, the participants' accounts conveyed doubts as to symptom improvement (Mira, Alisa), describing feeling fearful and anxious or uncontained and alone (Hailey, Helen). The participants expressed feeling silenced and not heard (Hailey, Alisa), confusion around goal setting or the direction of their therapy, and collaboration to establish trust and safety (Mira, Alisa, Helen). This has been identified in other studies. Chouliara et al. (2011), for example, states that disclosure was something which should be listened to, treated with great care and tenderness, and responded to with empathy. Disclosure in the early stages of therapy is a fragile and delicate stage in which therapists need to be mindful of possible re-traumatisation and of participants' capacity to trust in others, and their relationship history prior to therapy (Chouliara et al., 2011). Although research studies are limited, three reports from the literature review, though not directly related to disclosure, suggest a clear link between early PTSD therapy sessions and clients' abilities to develop trust. For example, Markowitz et al.'s (2017) study, suggests that non-TFT IPT focus on those feelings to help clients understand relationships and gauge trust in others and may be a better model for clients who have experienced sexual assault. Campanini et al. (2010) reported that the non-exposure component to traumatic memories of IPT, means that it concentrates instead on PTSD symptoms of interpersonal impairment post assault, such as social isolation, difficulty in establishing trust in others and low self-esteem. However, at variance with the

48 Danieli (2010, p. 195) defines re-traumatisation as a "reaction to a traumatic exposure that is coloured, intensified, amplified, or shaped by one's reactions and adaptational style to previous traumatic experiences". Recounting the traumatic event may carry reminders of the original traumatic event, and to the re-emergence of symptoms previously experienced as a result of the trauma (Danieli, 2010).

preceding two reports, Proença et al.'s (2019) study, found similar reductions in treatment effect and disengagement rates for IPT that is comparable to research applying TFT for sexual assault PTSD. This introduces the possibility that exposure to trauma therapy alone, for the treatment of sexual assault PTSD, may not influence participants' decision to disengage.

PTSD psychological symptoms, such as avoidance, issues of trust and emotional regulation difficulties have often been cited as potential barriers to forming a strong relationship in therapy (Howard, Berry and Haddock, 2021). The literature review suggested that concerns of TFT for PTSD may further damage the therapeutic relationship, increase client disengagement, or even exacerbate symptoms due to exposure of the traumatic memories, without the safety of the interpersonal bonds of the relationship that are central to emotional and psychological healing. Sexual assault PTSD can disrupt survivors reconnecting in interpersonal relationships. The therapeutic relationship can offer a source of reflection and reconnection of interpersonal relatedness within the safety of the therapeutic framework, and therefore is considered an essential component of successful therapy, independent of therapeutic approach and outcome measures, and is shown to predict better therapy outcomes (Ardito and Rabellino, 2011).

Sexual assault PTSD can damage clients' abilities to trust, and thus their ability to enter into a trusting relationship. The therapeutic relationship requires collaboration, a bond of trust, and agreement of the goals of therapy; all of which need to be developed in mutual cooperation (Chaudoir and Fisher, 2010). However, these are precisely the difficulties which the client with sexual assault PTSD struggles with when she enters therapy (Chaudoir and Fisher, 2010). Principles of collaboration promotes empowerment, informed choice and shared decision-making engendering trust and confidence in the therapy and the therapist. Encapsulating cultural and gender competences in these principles are integral for good practice approaches (Elwyn et al., 2012; Schouler-Ocak 2015). The therapeutic relationship is a working relationship, which may have ongoing difficulties with sustaining and nurturing clients who have been sexually assaulted, from the outset. Navigating disclosure, therefore, can be impacted by these difficulties for both the client and the therapist.

The participants' experiences suggested something about different therapeutic approaches that could be linked to more effective disclosure. For example, TFT approaches for PTSD, such as CBT, are cognitive approaches and do not generally focus on transference and countertransference processes, since the main aim is to reduce PTSD symptoms (Lord, 2008). Similarly, a non-TFT PCT approach does not process unconscious transference and countertransference feelings. The experience of the participants suggests that interpersonal disclosure became hampered by a lack of attunement and containment in the therapeutic relationship. Hence, the participants attempt to navigate *when* disclosure would be safe for them, was disrupted, perhaps due to lack of safety and trust resulting in defensive avoidance and distancing behaviour (Lord, 2008). The distinctive features of non-TFT PDT, working transferentially, may have allowed the therapist insight into the participants' unconscious communication, and by their defence mechanisms, projections, re-enactments, and avoidance, may have shed light on participants' current interpersonal and intrapsychic difficulties, making conscious those patterns with the client and possibly creating trust, safety and developing a therapeutic relationship. Transference and countertransference re-enactments are powerful vehicles for communicating to the therapist the quality of the relational experience in the developing relationship (Card and Knight, 2016).

The therapist's emotional responses may have become disrupted during the integral disclosure sessions, which might potentially be due to parallel process, in which the therapist may have experienced something similar to the participants' disclosures. Possible unconscious identification with the client's material could be suggested in the therapist's defensive stance. The skill of the therapist to attune may have been compromised as a result, and unconsciously defended against taking in the participants' disclosures. Parallel process can occur for many reasons, for example, if the therapist is insufficiently aware of her own identification with the client's material in the transference (which is possible if the therapist's approach is a non-directive PCT approach) that may develop due to differences in attuning abilities, insufficient training, and/or the influence of the participants uncomfortable projections, which the therapist may unconsciously defend against. When there have been specific traumas in a client's life, such as sexual assault, and when aspects of the self have been denied interpersonally, failure of contact in the early disclosure stage of therapy can repeat a

damaging relational pattern for the participants in a parallel process dynamic (Erskine, 1998).

The concept of containment might be helpful to understand, since in order to contain a client's subjectivity, the therapist also needs to contain her own. Containment of a client means the therapist has to bracket her own subjective material in order to hear the client's. In doing so, the therapist holds a mirror to the client as a model, in consciously communicating that she is a contained container (Bion, 1962), with sufficient emotional literacy and rigour to withstand both her own and the client's material, without overwhelming, persecuting or feeling the *pull* of the client's projections and acting on them (Finlay, 2016). For the therapist, the ability to tolerate, know and feel that which the client cannot, can be a painful process, and they may struggle to endure the client's projections (Gait and Halewood, 2021). Should the therapist fail to provide a containing agency, the client's projected thoughts and feelings are returned unchanged, resulting instead in two people coming together in therapy in a cycle of moving towards and resisting each other (Gait and Halewood, 2021).

Avoidance

Findings from existing literature for TFT outlines re-experiencing in therapy to be one of the ways in which clients begin to come to terms with their experiences, since it has been found to be harmful to survivors' mental health and quality of life (Tiihonen Möller et al., 2014). Tiihonen Möller et al.'s (2014) research on post-assault functioning for victims of sexual assault, and the consequences for mental health, reported that intrusive re-experiencing in therapy through memories or reminders of the assault, precipitated clients' avoidance to remember. This finding was echoed in the participants' accounts in this project, with defence and avoidance behaviours illustrated by Mira, Alisa, and Helen.

From the study conducted for this thesis, reports from the literature were consistent with participants' interview responses, indicating that disengagement rates have been associated with PTSD symptoms of re-experiencing or hyperarousal provoking

avoidance. Alpert et al.'s (2020) study predicted negative physiological responses[49] and overgeneralisation[50] were associated with a higher likelihood of disengaging from TFT. The relational therapeutic approach of FAP develops a supportive framework targeting core symptoms of PTSD re-experiencing and hyperarousal, in recognition of those symptoms' influence on avoidance and outcomes (Pedersen et al., 2012). Pedersen et al.'s (2012) study for example, indicated that CBT treatment for PTSD, followed by non TFT FAP intervention, revealed that treatment was effective at reducing both symptoms of PTSD re-experiencing and hyperarousal, and interpersonal functioning avoidance and detachment were also reduced.

From this thesis, it was possible to identify a sense of the participants' avoidance to voice the assault experience, expressed as silences (Alisa), monitoring and vigilance of safety and trust in the therapeutic relationship (Mira, Alisa, Helen), moving between heightened states of hyperarousal, re-traumatisation and dissociating (Mira, Helen), struggling to ease into safety (Mira, Alisa, Helen), and shifting their focus onto the therapist's lack of skills as a means to avoid the trauma narrative (Alisa, Hailey, Helen). Consistent in existing literature on addressing a difficult subject that a client might be avoiding, is the suggestion that it causes all subsequent interactions between therapist and client to be distorted, as they carefully avoid mentioning what they are both thinking (Berk and Parker, 2009). As such, it becomes impossible to have an authentic, meaningful dialogue (Orlinsky, Botermans and Rønnestad, 2001).

Reflecting further on authentic dialogues in therapy, Martin Buber (1878-1965) emphasised the client-therapist encounter as the fundamental source of healing in psychotherapy (Martin, 2017). According to Buber (1937), human beings experience two types of relationships: I-It and I-Thou. In I-It relationships, the other is an object to be used for one's own needs. For example, psychotherapy research for empirically validated methods and interventions for PTSD approaches are designed to measure

[49] Physiological response: aspects of arousal shown by physiological responses, such as increases in blood pressure and rate of respiration and decreased activity of the gastrointestinal system. Such primary arousal responses are largely governed by the sympathetic nervous system, but responses of the parasympathetic nervous system may compensate or even overcompensate for the sympathetic activity (APA Dictionary of Psychology, 2020).
[50] Overgeneralisation: a cognitive distortion in which an individual views a single event as an invariable rule, so that, for example, failure at accomplishing one task will predict an endless pattern of defeat in all tasks (APA Dictionary of Psychology, 2020).

therapeutic effectiveness for individuals by way of the client as object. I-Thou relationships involve the acknowledgement of the other person and view the partnership as relational rather than experiential. The interpersonal processes between therapist and client are difficult to quantify because they possess qualities that are difficult to measure and analyse (Ahmed, Westra and Constantino, 2012). Buber's (1937) dialogical therapy advocates an approach in which the relationship is *mutually* influenced between client and therapist, emphasising the client-therapist encounter as central to healing in psychotherapy, and the ideal mode for individuals to feel connected in relationships (Scott et al., 2009). The I-Thou relationship in therapy refers to moments when therapist and client come together in an authentic and meaningful dialogue, to bring a deeper richness to the encounter, moving beyond those personal issues, characters, roles, etc., to see the uniqueness of each individual. This may have the effect of moving clients into meaningful interpersonal encounters in which ideas and feelings can be expressed more readily (Scott et al., 2009).

Findings from the interviews offer detailed insight into the participants' experiences of their initial therapy sessions, illustrated in accounts describing disclosure in therapy as 'absolutely terrifying' (Mira); 'it was so hard to talk about … I'm not really gonna talk about anything really uncomfortable' (Helen); and 'just reliving this again and again and again' (Hailey). Alisa (Participant 3) stated that she struggled to separate the feelings about the issue, from the feelings that she was having about the therapy. The participants' accounts are consistent with research studies highlighted in the literature review. For example, Gutner et al. (2016) suggested participants' avoidance behaviours are illustrated when they disengage early from PTSD treatment owing to the component of TFTs that requires them to face their trauma. They reported that most participants in their study disengaged within the first half of the course of treatment and a large proportion disengaged prior to the first treatment session before receiving any treatment. Lewis et al.'s (2020) systematic review of recommended PTSD treatments examined differences in client disengagement rates from across all TFTs for PTSD modalities and found those psychological therapies with a trauma focus were associated with greater disengagement. The authors suggested client difficulties in tolerating TFTs as one explanation for increased rates of disengagement. These findings suggest client re-experiencing during disclosure can elicit powerful re-experiencing and avoidant defensive responses that can undermine

their decision to return to therapy. Perhaps this is linked to the threat to a sense of self not properly established early in therapy.

One study from the current literature, at variance with Gutner et al. (2016) and Lewis et al. (2020), found a pre-treatment-to-post-treatment decrease in PTSD symptom severity that was sustained at follow-up in an intensive four-day TFT, in which none of the participants in the study disengaged (Hendriks et al., 2018). The authors speculated that standard weekly TFT may leave clients with more time to engage in avoidance behaviours between sessions as a possible explanation for these findings. Research investigating the link between short-term intensive PTSD therapy and standard weekly therapy for sexual assault PTSD and reduced disengagement is limited. It is an important finding in terms of disengagement in PTSD therapy that merits further research regarding reducing disengagement rates.

The theoretical framework of constructivist self-development, integrating psychodynamic theory with theories of social cognition, may provide a link to the impact of sexual assault on the participants' abilities to develop and maintain a consistent sense of self in therapy (Pearlman, 1997). It has been established that engaging in trusting, consistent relationships with others post assault, is complex and difficult for survivors. Constructivist theory determines the way that individuals construct their own reality. According to McCann and Pearlman (1992), an individual's unique history and experiences will shape a traumatic event, and thus define how they adapt their frame of reference (or identity and world view) to shape their therapeutic engagement. The authors suggest approaches for trauma therapy can include three aspects of the individual's sense of self that are affected by trauma. These include self-capacities (self-regulation and regulation of self-esteem); cognitive schemas (beliefs and expectations about self and others or world view); and intrusive trauma memories and related affect (McCann and Pearlman, 1992). This blend of three psychological dimensions: self, traumatic memories, and psychological needs and related cognitive schemas, may provide the necessary platform in which to enhance and navigate clients' defensive responses to trauma in therapy that may trigger severance, avoidance or disconnection during disclosure.

Emotional Regulation and Resilience

The term resilience is generally used to describe the capacity of people to adapt and recover from traumatic experiences. The primary factor in resilience is in supportive relationships that create trust and provide role models of safety and reassurance. Southwick et al. (2014) proposed the need for a definition of resilience before we can understand what the important determinants of resilience are for the client, and for insight into the most effective ways to enhance resilience. Overall, however, there is an agreed concept of resilience that is in the development of a healthy, adaptive, or integrated positive functioning, developed over time in the aftermath of trauma. For the purposes of this study however, healthy adaptive functioning developed over the course of therapy, is the definition of resilience here.

It was apparent from the accounts shared in this thesis, that the participants exhibited a threat to the sense of self caused by the traumatic event and its relationship to difficulties in self-regulation. Key aspects of concern for the participants were the resurfacing of traumatic memories and a disruption to their self-managed stabilisation. Their shared experience of therapy suggests an escape from or an avoidance of remembering, pointing to a lack of resilience, in such statements as, 'it was more what I was doing for myself in therapy' (Mira); 'I couldn't even think straight' (Hailey); 'I didn't feel like I was making any progress' (Alisa), and 'I'm gonna move out of the area' (Helen). The finding that those entering therapy with trauma-related interpersonal disruption like sexual assault may have difficulty in developing regulation and resilience skills and attitudes within a therapeutic relationship, is consistent with existing literature (Keller, Zoellner and Feeny, 2010). In sexual assault PTSD therapy, compromised interpersonal functioning can be a factor that impedes and challenges the development of early relationships (Keller, Zoellner and Feeny, 2010). This is echoed in research reporting that the worse interpersonal functioning is found across a variety of domains including intimate relationships, family life, and social situations (Hill, Pilkonis and Bear, 2012). Interpersonal difficulties associated with PTSD have been linked to feelings of detachment from others, diminished interest in activities, and restricted affects. Client interpersonal difficulties may impact therapy outcomes, either directly or through the mediating therapeutic relationship. Research has indicated that greater pre-treatment interpersonal difficulties were

associated with increased risk of disengagement and poorer outcomes (McEvoy, Burgess and Nathan, 2014), and difficulties in emotional regulation were risk factors for the development of PTSD, and successful recovery from trauma requires adaptive emotional regulation (Tull et al., 2007).

The participants' accounts were consistent with reports identified in research by Campanini et al. (2010), Markowitz et al. (2017) and Proenca et al. (2019), which examined IPT to treat sexual assault PTSD. Their research suggested that increased disengagement rates might be due to exposure to the trauma component in certain TFT therapy models. Markowitz et al. (2017) compared disengagement from TFT PE with two non-TFTs IPT and Relaxation Therapy (RT) and reported findings indicating that IPT had marginally reduced disengagement rates and increased response rates compared to TFT PE. Similarly, IPT as a stand-alone treatment in studies by Campanini et al. (2010) and Proenca et al. (2019), indicated positive outcomes for both reduced symptoms of PTSD and disengagement rates.

Findings from a further three studies corroborated the participants' accounts, recognising that emotional regulation and resilience were key to sustaining therapy sessions with clients to reduce the risk of disengagement (Frye and Spates, 2012; Bryant et al., 2013; Shnaider et al., 2021). Frye and Spates (2012) investigated non-TFTs during PE treatment and found that mindfulness and emotional regulation skills augmented stabilisation for the exposure phase of PE, indicating that skills training in mindfulness and emotional regulation played a role in reducing anxiety sensitivity. Bateman and Fonagy (2012) suggest in the absence of mentalisation in therapy, emotional regulation can also be undermined, such that instead of a client being able to *think* about feelings, they become enacted instead, in an unconscious dynamic that is played out between therapist and client. Ideally, the therapist may reflect on, for example, what it might reveal about a client's relationship patterns. Once it is made conscious, however, there is a possibility of the therapy moving forward again, where both therapist and client have a new awareness of the client's mentalising inner world (Bateman and Fonagy, 2012). When enactments are not made conscious, however, the therapeutic relationship and the therapy can become compromised beyond repair.

Intellectualisation refers to a defence mechanism in PDT, described as a client who might psychologically translates emotional issues into intellectual terms, such as defending against feelings around the traumatic material (Arnold, 2014). The purpose of intellectualising is to redirect attention away from affective experiences and onto thought processes that are emotionally detached. In the absence of the development of attunement in establishing a therapeutic bond early in the process, however, may be interpreted as contributing to difficulties in gauging the client's preparedness and resilience to move towards traumatic affect in therapy (Arnold, 2014). There was suggestion that Mira and Alisa intellectually defended their feelings in therapy, possibly to seek safety from a therapy relationship that threatened to touch on terrifying or uncomfortable material. When Mira described herself as "practical" (line, 400) and "doing" (line, 401) may reflect an intellectual defense to avoid confronting traumatic memories. Failure of the therapist to recognise and address such defensive communications may point to issues in the development of attunement and rapport. Alisa, similarly, might be intellectually defended when she described herself as "thinking" and someone who liked to "analyse" and "rationalise" (line, 369), possibly signally issues in the developing relationship, when the therapist did not gauge the participants defensive stance or their resilience to begin trauma work.

Bryant et al. (2013) proposed that exposure (confronting the trauma) in therapy can precipitate high levels of disengagement, and so their study included pre-treatment training in emotional regulation to enable participants to manage any distress caused by exposure to trauma memories. Their results showed greater symptom functioning at follow-up compared to those clients who did not receive pre-treatment training. Similarly, Shnaider et al.'s (2021) study examined the impact of pre-treatment emotional regulation difficulties on treatment effectiveness and disengagement in PTSD. Their findings indicated significant improvement in PTSD symptom severity and reduced disengagement. Establishing rapport and identifying helpful approaches at the beginning of therapy can develop clients' resilience. Littauer, Sexton and Wynn's (2005) findings, for example, indicated that clients regarded connection-shaping factors, such as the therapist's accepting understanding, as being the most important in therapy. These studies recognised the fragile states of clients when exposed to traumatic memories in therapy, resulting in possible avoidance of and

disengagement from those memories, and hence therapy, due to a lack of emotional regulation and resilience.

The experiences of the participants who shared in this thesis reveal the challenges faced when recounting potentially retraumatising material in therapy in statements such as: 'at one point I felt I didn't need it anymore, the process I was going through it was more what I was doing myself' (Mira); 'I needed someone to do the therapy for me' (Hailey); 'I didn't feel like I was making any progress or like it was useful to me in any way' (Alisa), and, 'I did the whole massive routine' (easing out) (Helen). Their experiences suggested shutting down, avoiding, or escaping traumatising effects. In ego psychology this could be interpreted as the ego employing protective mechanisms to defend the self from experiencing the threat of disintegration[51]. Alisa attended the most sessions, indicating sustained avoidance of trauma work in therapy, and a lack of intervention to develop emotional regulation and resilience to begin to address it. Other studies are consistent with these findings, reporting that effective coping skills like emotional regulation are highly influential in resilience following negative life events (Scoglio et al., 2018). Rothschild and Eichhorn (2017) argue that trauma memories should not be addressed in therapy before the client is equipped to manage the distress. Other research suggests that resilience is associated with greater recovery from PTSD (Davidson et al., 2005), as well as reduced occurrence and symptom severity (Nemeroff et al., 2006). The participants' experiences demonstrated their difficulty to emotionally stabilise when recounting sexual assault memories in therapy, expressed in ambivalent statements such as: 'too stressful' (Helen); 'it's not useful to me in any way' (Alisa); 'I don't think it would have been helpful to me' (Hailey), and 'I didn't need it anymore' (Mira). Participants' ambivalence might have been related to the anticipation of negative emotions (for example, guilt, shame, or fear) that can arise in the wake of disclosure (van Harreveld, van der Pligt and de Liver, 2009). Other reports from existing literature claim that ambivalence in therapy involves the simultaneous move towards and away from change as an approach-avoidance conflict (Morris, Dollard, and Miller, 1951) that if not properly resolved, can negatively impact treatment outcomes (Braga et al., 2016; 2018). Additional research investigating the synergy between client ambivalence and the development

[51] Disintegration: a break. up or severe disorganisation of some structure or system of functioning, for example, of psychic and behavioural functions. https://dictionary.apa.org/disintegration

of emotional regulation and resilience and disengagement, may help to explain this effect further.

Emotional regulation processes are relevant to a number of therapeutic constructs in PDT, such as defence mechanisms, internal working models, coping strategies, and ruptures and reparations of the therapeutic relationship (Palmieri et al., 2022). Insight into clients' inner world, and working within the transference, can draw on knowledge that relies primarily on interpreting the relationship between therapist and client, to help identify clients' attitudes and beliefs about how they cope with difficult and challenging thoughts and feelings that may arise in therapy around the trauma (Prout et al., 2019). The PDT construct of defence mechanisms further elucidates clients' coping patterns and strategies by affording observable, measurable expressions of implicit emotion regulation in therapy. As the therapist addresses the nature of clients' defence mechanisms, the therapeutic dyad enhances the implicit emotion regulation, making defence mechanisms more conscious (Prout et al., 2019).

Interpersonal emotional regulation seems to be the common thread woven in similar constructs, such as Bion's (1962) idea of therapeutic containment, Winnicott's (1949) notion of the holding environment, and the interpersonal influences in attachment theory (Bowlby, 1988) (Palmieri et al., 2022). If emotional regulation processes are core mechanisms underlying therapeutic change, then those mechanisms specific to PDT, such as therapeutic containment, holding environment, and attachment-related psychodynamics, along with the therapeutic relationship, may have powerful regulative means to influence engagement and outcomes (Palmieri et al., 2022). It also suggests that participants may have benefitted from a non-TFT approach such as PDT, since sexual assault is an interpersonal traumatic wound, where healing can begin to take place within the safety of those therapeutic constructs.

Southwick et al. (2014) suggests that determinants of resilience need to be approached empirically in research from a multi-layered perspective including genetic, developmental, demographic, cultural, economic, and social variables: a more holistic empirical approach, that may inform client resilience and enhance well-being on

numerous levels, for example, the individual, family, community, and culture (Southwick et al., 2014).

Client-Expectancy Effects

Existing literature on treatment credibility and expectancy violations impacts both the process of therapy and its outcome (Westra, 2010). Westra's (2010) findings suggest that negative expectations of the therapist and/or the therapy, are common and potentially powerful phenomena in the experiences of clients. Therapists' facilitation and development of a collaborative, noncoercive approach in therapy can encourage participants to engage in the therapy process, often confounding participants' expectations (Westra, 2010). Westra (2010) suggests that expectancy violations evoke more powerful affective responses than expectancy confirmations, and that future research to further expound how expectation–experience discrepancies shape interpersonal processes and contribute to outcomes in TFTs, and other types of psychotherapy, would be beneficial. The participants' accounts called attention to a lack of belief regarding treatment credibility and the overall expectation of symptom improvement during the initial stages of the therapy process. This might link the insufficient development of therapists' interpersonal skills to establish a good-enough, stabilising therapeutic relationship.

Attunement

There were powerful themes shared across all participants' experiences of therapy of a lack of attunement in the therapeutic relationship, and a very felt sense of their motivation to remain beginning to erode. This was echoed in the participants' interviews with statements such as: 'I need to sit down and feel like I'm actually doing something to solve the issue' (Mira); 'it's unfortunate because the way the framework they were using to view the whole issue was so divergent' (Alisa); 'you have [private] therapy for so long because you pay them that was one of my [concerns] (Hailey); 'I think she said to me that it was … sort of dangerous what I was doing like working in ... you know talking about like sort of retraumatising myself' (Helen). Negative therapy expectations were strongly indicated in the participants' responses, questioning their beliefs both in their therapists, and the

extent to which they expected therapy to improve their symptoms. The participants may have felt unable to relate to their therapists, which could be interpreted as lack of attunement. Mira, Helen and Alisa felt unable to relate to their therapists, and Hailey was concerned hers might take advantage of her vulnerability. These findings are consistent with other research, indicating that client expectations of therapy are a strong predictor of disengagement (Taylor, 2003; Greenberg, Constantino and Bruce, 2006). Barrett et al. (2008) suggested that beliefs regarding treatment credibility and the overall perceived "fit" of treatment may be particularly salient to engagement during the initial stages of the therapy process. Jackson (2015) argued for therapists' honesty to manage clients' expectations, suggesting clear and transparent communication about what can and cannot be achieved in therapy. Exploring the risks as well as the benefits of therapy to manage clients' expectations and informing them when setting the goals of therapy early in the relationship, will develop attunement, trust, and client engagement (Jackson, 2015).

Reflecting on the client's ability to engage, Bohart (2000) suggests that the therapist's training, approach, and experience matter less to clients than does her personal qualities. Furthermore, the quality of the relationship, developed early in therapy, was found to be more important to clients and was the best predictor of outcomes (Bachelor and Horvath, 1999). If clients felt a sense of compatibility or were accurately perceived by the therapist, then this encouraged and instilled confidence to enable clients to invest, suggesting that therapists' capacity to engage clients and offer them attunement and rapport is more important than professional expertise (Bachelor and Horvath, 1999). This is an interesting statement in thinking of TFT and non-TFT approaches for PTSD introduced in the earlier chapters in this thesis. TFT approaches centralise model and technique over the relationship, and the reduction of PTSD symptoms in TFT approaches is a sign of successful outcomes. Non-TFT approaches centralise the wellbeing of clients presenting with PTSD for improvement in their quality of life, yet similar rates of disengagement are experienced in non-TFT approaches. If research suggests that attunement and rapport are more important than professional expertise, this means the development of attunement for the sustained maintenance of the therapeutic relationship promotes therapeutic engagement in sexual assault PTSD.

Attunement communicates to the client that a therapist can identify and share their needs and feelings. The development of attunement in the therapeutic relationship is crucial to the client's sense of self and interpersonal relatedness, and it is an important part of the process of healing (Erskine, 1998). Interpersonal relatedness refers to the need to establish close and nurturing relationships. Effective therapeutic attunement can set the foundation for reparation of a client's relationship failures (Erskine, 1998). Also significant in the development of attunement might concern the influence of mentalisation. In PDT theory and practice, mentalisation is thought to be a component of healthy personality development and secure attachment. Mentalisation is the ability to understand one's own and others' mental states, learned as infants, to comprehend one's own and others' intentions and affects. Bateman and Fonagy (2012) explained that observed cues in infant/caregiver behaviours, such as eye contact and tones of voice, for example, motherese,[52] generate secure attachment. These sensitive, observed behaviours towards the infant, termed 'epistemic trust', develop a sense of caregiver trustworthiness and reliable information for the infant (Fonagy and Allison, 2014, p.372). Failure of the caregiver to generate such dyadic behaviours, may result in the authentic and personal relevance of such interpersonally transmitted cues and behaviours in infancy to become compromised in adulthood (Sperber et al., 2010; Wilson and Sperber, 2012). Fonagy and Allison (2014) theorise those deprivations of epistemic trust as infants, is a deprivation of mentalisation skills for social and cultural knowledge in adulthood, and potentially, may have influenced attunement in the developing therapeutic relationship in all of the participant's therapy.

A teleological mode of non-mentalisation, for example, when perceived action to achieve goals and purposes is sought through objective, accessible facts, such as when Alisa requested concrete evidence from her therapist to gauge her progress, may also have influenced development of attunement in Alisa's therapy (Allen and Fonagy, 2014). When a client is focused on the therapist hearing out the full history of her experience, for example, when Alisa suggested feeling silenced to disclose her story that "takes a while to explain" (line, 58), may have demonstrated to her therapist that

[52] Motherese is the distinctive form of speech used by parents and other caregivers with infants and young children. It is characterised by grammatically simple and phonologically clear utterances, often delivered in a high-pitched sing-song intonation. https://dictionary.apa.org/motherese

she was in an established pattern of rigid points of view, instead of seeking opinions that are open to alternative perspectives. Allen and Fonagy, (2014) suggest that when a client is not mentalising, it elicits the 'mentalising therapist' to focus on bringing the client's awareness back to a mentalising stance (Jensen et al., 2021, p.3). By re-establishing a curious stance about the client's thoughts, feelings, and intentions, engagement might be re-stimulated, and attunement promoted (Allen and Fonagy, 2014).

Some researchers have used the therapist's judgement as a criterion for defining disengagement. For example, Keefe et al. (2018), proposed that client disengagement from PTSD therapy may be due in part to a therapist's 'intuition'[53] regarding the best treatment for clients. However, with little systematic data or comparative studies to draw on concerning therapists' judgements, this was difficult to substantiate in their study. There is a growing body of research of therapists' use of intuition in clinical practice, especially in cognitive psychology, and a number of learning theory models of intuition have been developed (Betsch, Henning Plessner and Tilmann Betsch, 2008). A definition of intuition is difficult to ascertain, but Dane and Pratt (2007, p.40) define it as 'affectively charged judgements that arise through rapid, non-conscious, and holistic associations'. Intuition, then, is a problem-solving strategy that arises due to implicit, cognitive application of tacit learning. It is based on cues that are triggered, allowing information stored in the memory to tacitly discover a heuristic approach to learning (Betsch, Henning Plessner and Tilmann Betsch, 2008). This cognitive definition provides a one-person model: it is a process that occurs in the mind of the intuitive. An important distinction, therefore, between the cognitive theories of intuition and those of psychotherapists is the level to which clinical intuition may be interactive (Stickle and Arnd-Caddigan, 2017).

An alternative explanation of intuition, and more relationally applicable, is represented in the work of psychotherapists. For example, research indicates that unconscious communication may be based on unconscious micro-expressions and non-verbal cues (Schore, 2005), or the result of a basic connection between people

[53] Intuition: 1. [uncountable] the ability to know something by using your feelings rather than considering the facts. 2. [countable] an idea or a strong feeling that something is true although you cannot explain why (Oxford Advanced Learner's Dictionary, 2022).

(Jeffrey and Stone Fish, 2011). More specifically, in the relationship with the client, the therapist's ability to use the relational framework of psychotherapy may be enhanced by the use of intuition. Research by Jeffrey and Stone Fish (2011) reported that clinical intuition emerges from a deep connection with the client, and Stickle and Arnd-Caddigan (2017) demonstrated that clinical intuition is a valuable tool in psychotherapy that may contribute to the therapeutic relationship and positive treatment outcomes. Erskine (2011) for example, referenced intuition in relation to attunement in the importance of the therapeutic relationship, placing intuition at the very core of relationship development. Differing capabilities and capacities of therapist effectiveness and the addition of these therapeutic tools for the development of the client-therapist relationship is an under-researched area in the field of disengagement.

The participants spoke about the lack of rapport and interpersonal communication in their relationship with their therapists. Insight into some of these themes highlighted negative expectations of the therapist in statements of resignation and helplessness, such as: 'I think that we were incredibly different as people' (Mira); 'I think the combination of sand and stone both being different just meant there wasn't any chance' (Alisa); 'I was also worried on the other side that someone would take advantage of you' (Hailey); 'I felt like I'm doing something really unethical kind of thing like by continuing to work' (Helen). From the literature review, one report was consistent with these findings, identifying treatment credibility beliefs and expectations linked to disengagement. Kline et al.'s (2020) comparison study examined pre-treatment predictors, to nonstarters, starters, and client disengagement in TFT. They identified increased disengagement rates, with a substantial minority being nonstarters, citing differences in participant beliefs (perceived credibility of the treatment) as a factor for increased disengagement. These findings link with those found in this thesis when, other than P3, participants remained silent about their doubts of therapy, possibly pointing to a non-collaborative therapy or a too-fragile relationship. The remaining participants' thoughts and feelings of doubt were felt, but they remained unsaid and unprocessed in therapy, suggesting negative perceptions of therapy (or the therapist) cannot be expressed aloud to the therapist and possibly pointing to difficulties within the relationship linked to trust, collaboration, and

agreement of goals. This may also, perhaps, mark the introduction of a dyadic power differential in the relationship (Knox et al., 2011).

There appears to be two separate impressions from the participants' therapy experience. The first is credibility of the therapy model and how believable, convincing, and logical the therapy seems to them. Research suggests that according to clients, the credibility of a therapy model is associated with other common therapeutic factors, such as treatment engagement, therapeutic relationship, and outcomes (Thompson-Hollands et al., 2014). Clients' 'role' expectations may not resonate with the theoretical model of the therapist, such as a client who sees a TFT therapist expecting to discuss her childhood memories (Glass, Arnkoff, and Shapiro, 2001). Orlinsky, Ronnestad and Willutzki's (2004) study concluded that client 'role preparation', which includes providing a credible treatment rationale, was linked to client engagement. The second possible perception of participants' expectations of therapy is their preference for a particular model (Tracey and Dundon, 1988). Researchers have examined preferences for type of therapy by comparing the outcome of clients who received their preferred method with the outcome of clients who received a treatment other than the one they preferred. Informing clients about PTSD treatment options and preferences was shown to promote shared decision making (Kwan, Dimidjian and Rizvi, 2010), which was also shown to improve treatment outcomes (Swift et al., 2018). Shared decision making is collaborative, and a necessary component for the development of trust in the therapeutic relationship.

Schwartzkopff et al.'s (2021) comparison study of TFT and non-TFT approaches for PTSD showed that clients were more likely to choose exposure therapy and CBT over PDT or EMDR (Harik, Grubbs and Hamblen, 2020). In addition, therapies such as meditation and yoga, were less preferred by clients than established treatments, such as CBT or exposure therapies (Najavits, 2015; Simiola et al., 2015). The paucity of available research exploring PTSD clients' preferences for non-TFT stabilisation and PDT approaches, makes it difficult to draw meaningful conclusions (Schwartzkopff et al., 2021). For example, despite claims made in Tarrier et al. (2006) that highly preferred, endorsed treatments for PTSD included CT, exposure therapies, or psychoeducation (notwithstanding the discomfort anticipated with exposure), over PDT, PDT received the lowest preference endorsement by clients. In contrast,

Schwartzkopff et al.'s (2021) study did not find significant differences between client preference rates for exposure therapies, CBT, EMDR *and* PDT. Additionally, findings from the research field of PTSD treatment preferences do not correspond with research for TFT approaches and disengagement, since outcomes for clients' non-response to TFT are as high as 50% (Schottenbauer et al., 2008)

Client-Perceived Therapist Effectiveness

The participants spoke about their frustration in therapy. The experience of their shared accounts of therapist effectiveness conveyed annoyance at unsolicited therapist interventions not initiated by the participant (Alisa, Helen), and a lack of attunement (Mira, Alisa, Helen). The participants also conveyed a sense of not being heard (Mira, Hailey, Alisa), of poor communication by the therapist (Hailey, Alisa, Helen), of a lack of clear goals or direction in therapy (Mira, Alisa), and of not feeling understood or feeling confused (Mira, Alisa, Helen). There is scant research in the field of client-perceived therapist effects, especially concerning disengagement, and that which is available focuses on positive treatment outcomes and/or symptom improvement (Xiao et al., 2017).

Research that is related to client-perceived therapist effectiveness suggests that therapist ratings of disengagement are an unreliable source of data, and too biased without the perspective and actual functioning of the clients involved (Hatchett, Hanand Cooker, 2002). Research by Elliott and James (1989) revealed clear differences in ratings of therapy process and outcome by client and therapist. For example, client perceptions of the therapeutic relationship or therapist style of relating (i.e., feeling attuned) were shown to predict outcome measures that were more reliable and less biased than ratings by therapists. In addition, Imel et al. (2015) found that satisfaction measures, such as treatment evaluations, were typically only given to a subset of clients and were "notoriously skewed", and available only from those clients who completed treatment, and not consistently related to treatment outcomes (Imel et al., 2015, p.330).

Findings from this thesis offer a detailed insight into how the participants' therapy sessions became progressively unsatisfying as their therapists were not attuned to meet their needs. This therapist-centred approach was illustrated in statements such as: 'can we start doing something in a way and I guess that in the last moment she would have been more positive proactive' (Mira); 'some of the things that were said I remember getting quite annoyed about' (Helen); 'I didn't think she was really special' (Hailey); 'this isn't working between us you know communication isn't really working very well' (Alisa). The therapeutic approaches discussed and outlined in the literature review, Chapter 2, can be linked to the participants' experiences of therapy. For example, the participants described not working in the transference and countertransference process (e.g., communication isn't working); a non-directive therapist (more proactive); and unrepaired ruptures and lack of attunement in the developing relationship (getting annoyed at ill-timed/inappropriate interpretations).

Also, in the literature review, comparisons were made between TFT and non-TFT approaches and their effectiveness in the treatment of sexual assault PTSD and client engagement. Here, comparison of non-TFT approaches seems pertinent since the majority of models practiced at the WS are non-TFT. As implied above, it seems probable that the therapists were not working in the transference, or their own countertransference processes. The therapists also seemed to have adopted a non-directive approach, possibly classical PCT, or a variant of classical PCT involving dialogical and/or relational approaches that emphasise the two-way, therapist-client encounter. This contrasts with the wholly non-directive therapist stance of classical PCT and contemporary extensions merging with PCT, for example, a 'trauma-informed' approach (TIA), to provide a therapeutic approach to address PTSD. Whichever variant of PCT is adopted, the therapist will require the skills and experience to work in their model, whilst developing and sustaining a therapeutic relationship with the client (Joseph, 2004). Non-TFT PDT has the longest history as a method for dealing with trauma including sexual assault. PDT is focused on clients' expression of emotions, exploration of avoidance of distressing emotions, identification of defence mechanisms, working through interpersonal relationships and using the therapeutic relationship, conscious and unconscious process, and transference and countertransference, to address and resolve intra-psychic conflicts and interpersonal struggles (Shedler, 2010; Regehr et al., 2013). Irrespective of the

approach's rigour and empirical evidence in research for the appropriateness of the approach for the treatment of PTSD, if the therapist is deficient, inexperienced or lacks the skills to develop and sustain a relationship with a trauma client, therapy approach alone is not enough to engage a client to completion of treatment (Erskine 2011).

The client perspective is the most direct source of information about the client experience of therapy, including the felt quality of their therapeutic relationship, their immediate, unexpressed reactions to therapeutic interventions or events, and the aspects of treatment which they find most helpful (Elliott and James, 1989). Clients may be the only accurate source of information, providing important contextual information to clarify the meaning of an experience, and identify links between those experiences that might not be apparent to others (Elliott and James, 1989). Data from client perspectives, for assessing the validity of therapist effectiveness and ratings, is the only authentic approach to measuring therapist process and effectiveness (Elliott and James, 1989).

Without data from client perspectives on therapist effectiveness, we cannot learn what clients are saying they need and want from therapy that will induce them to remain in therapy. In order to improve therapy treatment outcomes and reduce disengagement rates, we must learn from the client: research now needs to turn its attention to client perceptions of therapist effectiveness to investigate its impact on outcomes and disengagement.

Disengaging from Therapy

The findings illuminate the experience of dissatisfaction for the participants and show how they shifted from confusion; evident in themes such as a lack of goals and direction (Mira, Alisa), no observable symptom improvement or agreed therapy treatment planning (Mira, Alisa, Helen), to an awareness that therapy and the therapist were not meeting their needs. A lack of clarity about the therapists' treatment plan, her method of working, and the participants' preferences for therapy were not explored or explained sufficiently. For example, P1 reflected that, '… we weren't going anywhere' (Mira). It was not possible for the participants to proceed in therapy

if they had no awareness of the direction or goals agreed upon at the outset. A large body of evidence indicates the effectiveness of TFT approaches for PTSD in symptom improvement and outcomes, particularly TFT CPT and PE. For example, studies by Resick et al. (2012); Jayawickreme et al. (2014); Shnaider et al. (2014; 2021); Larsen et al. (2016); Van Woudenberg et al., (2018); Youn et al. (2019); Booysen and Kagee (2020) and Haven et al. (2021) found significantly greater pre-to-post-treatment reductions in PTSD symptoms compared to supportive counselling (Bryant et al., 2003) and relaxation training (Taylor et al., 2003). The NICE (2018) guidelines for the treatment of PTSD, outline the recommendations and rational for using TFTs, including a comprehensive treatment plan orientated around goal setting and interventions for reducing PTSD symptoms (see Appendix 5 for a complete outline of NICE guidelines for treatment interventions for PTSD in adults).

Other studies have also identified that beneficial change and/or reduced symptoms are essential indicators of engagement in therapy. For example, Barrett et al. (2008) found that clients will disengage from treatment if they recognise a lack of improvement in symptoms and believe that additional sessions will not be beneficial. However, it remains unclear as to the extent that TFT approaches and related gains in PTSD symptom reduction translate to improvements in those broader areas of the client's wellbeing and quality of life. For example, Berle et al.'s (2018) study to determine whether core symptoms of PTSD, such as anxiety, were associated with improvements in overall personal wellbeing, found that although personal wellbeing improved in line with PTSD symptoms, the improvement was not significant. The authors recommended the need for more research to better understand how improvements in personal wellbeing and quality of life can be optimised following PTSD treatment (Berle et al., 2018).

Two further studies investigated therapists' own explanations for client disengagement (Murdock, Edwards and Murdock, 2010; Piselli, Halgin and McEwan, 2011). Their findings indicated that therapists tend to focus on external reasons and over-simplified causalities attributed to the client for disengagement, rather than on their own contributions. The authors propose this might serve as a protective measure for professional identity. However, the bias in TFT approaches for PTSD research, also focuses on client factors for disengagement, thus confounding and restricting our

understanding of the phenomenon of disengagement from therapy, and those processes within the developing relationship between therapist and client. Without client evaluative data to provide evidence of participants' therapy outcomes, it is difficult to draw meaningful conclusions. Additional research investigating the therapist and client relationship process might contribute to our understanding of its impact on disengagement.

Client-Therapist Relationship

Bordin's (1979) definition of the development of a therapeutic relationship underlines a collaborative treatment between client and therapist in their common goal to overcome the client's suffering. According to Bordin (1979), the therapeutic relationship consists of three essential elements: agreement on the goals of the treatment, agreement on the tasks, and the development of a personal bond made up of reciprocal positive feelings (Ardito and Rabellino, 2011). When client and therapist share beliefs and have the same goals for treatment, the methods used to achieve these are effective and relevant, in order to achieve an optimal therapeutic relationship.

Therapist Effect on Outcome

Some therapists are more effective than others (Saxon et al., 2016). Therapist factors such as training, skill and experience, do not predicate successful outcomes (Saxon et al., 2016). Therapist effects can be defined as the systematic effects of therapists on client outcomes beyond that of the therapists' approach, technique, or number of years' experience (Saxon et al., 2016). Some therapy effects include, but are not limited to, influences such as the quality of the bond, level of agreement regarding the goals and tasks of therapy, and the therapists' ability to recognise and repair ruptures in the therapy relationship (Safran and Muran, 2000; Saxon et al., 2016).

The participants' experience of their therapy was clearly dissatisfying, however, except for P3, they remained silent, choosing to end therapy rather than communicate their dissatisfaction. These feelings were shared in statements such as: 'some physical things to do would have completely changed my attitude' (Mira), 'a friend of mine who was more appalled by it than me' (Hailey), and 'things that like stand out … I

didn't like them' (Helen). Direct communication of dissatisfaction about their treatment and progress to their therapist was, in the main, evaded or avoided, apart from P3 The participants' thoughts and feelings of dissatisfaction were *felt*, but they remained unsaid, and unprocessed in their therapy. Rennie's (1994) theory of client deference in therapy goes some way to explain the participants' silent dissatisfaction, of concern about criticising the therapist. However, there was also a sense from the participants that implicitly, therapists were sending the message that these thoughts and feelings were not supposed to be expressed aloud. For example, Rennie (1994) suggests that client deference to the therapist acts as a means of protecting herself in the relationship, yet this comes at a cost to the client's unspoken judgements about therapy, especially if negative, that might otherwise strengthen the working relationship and possibly improve outcomes if addressed. Speculation as to therapists' awareness of clients' negative appraisals and outcomes is twofold; the first is that therapists' awareness may draw the clients' attention away from herself as the focus in therapy, and second, awareness of their clients' negative appraisals of therapy, may impact therapists' confidence and performance and might disrupt the relationship. This latter speculation is a possibility in the participants' therapy experience: research has indicated that therapists with more skills and experience would necessarily be more adept at effectively dealing with their awareness of their clients' negative reactions (Hill et al., 1993). Therapists' knowledge that clients are inclined to be deferential to them may augment their sensitivity and judgement when assessing clients' negative appraisals in therapy, or indeed have a deleterious effect on outcomes, dependent on their experience, skills, and confidence.

Existing theoretical literature strongly suggests that perceived rules felt by clients in therapy, are an early indication of non-collaborative therapy (Ribeiro et al., 2013). The participants' experiences point to a non-collaborative therapy in which they were silenced by the therapists as the *professionals,* and not as the facilitators, with the possible emergence of a power-dyad in their therapy relationship. Collaboration is at the core of the therapeutic relationship and a consistent indicator of positive therapeutic outcomes. A non-collaborative therapeutic relationship may result if the participants perceive their therapy relationship as a repeating pattern of loss in supportive relationships, which may have been too difficult for them to endure

(Ribeiro et al., 2013). The participants' experiences suggest that this was a contributing factor to disengaging.

In considering another interpretation, we might also reflect on the participants' experience of power in their therapeutic relationships, perhaps driven by their traumatic experiences, and the complex relationship between persecutory ideation and the participants' subjective wellbeing coming under threat (Keyes, Shmotkin and Ryff, 2002). Persecutory ideation refers to thoughts that an individual believes that the persecutor (in this interpretation, the therapist) has the intention to cause harm (Freeman and Garety, 2000). The participants may have defensively projected this onto the therapist to protect themselves from a perceived threat and assuage any anxiety and conflict from arising. If the therapist can explore the reasons behind their projected feelings, it may be possible to prevent or reduce occurrences of projections and 'give back' the participants' projections in a safe form by making them conscious in the transference and countertransference process. If, however, the therapist is unable to recognise projections, the therapist may find herself reproducing participants' feelings of persecution and powerlessness in the therapeutic relationship, which the client may find unbearable, possibly leading to a serious therapeutic rupture or disengagement.

The participants' accounts were consistent with studies by Van Minnen, Hendriks and Olff (2010); Ehlers et al. (2013) and Proença, et al. (2019) for client therapist effects. Though not directly examining therapist effect on outcomes, Van Minnen, Hendriks and Olff (2010) examined the under-utilisation of TFTs by therapists and found that it was due to concerns of symptom worsening or disengagement, and/or a lack of training and confidence in their use. Although no therapist effects were significant, Ehlers et al. (2013) examined CT for PTSD in an NHS outpatient service that revealed a trend for inexperienced therapists to achieve fewer good outcomes than experienced therapists, and those therapists with less training choosing a non-TFT for PTSD. Proença et al. (2019) investigated non-TFT IPT for PTSD, to examine whether outcomes were similar to TFT PE to treat PTSD. Although their findings indicated similar disengagement rates for IPT equal to PE for PTSD, the authors suggest that despite similar training, therapists have different capabilities, reflecting different client outcomes; hence, it is possible for the performance of one therapist to produce

higher disengagement rates when compared to other therapists using the same therapeutic approach (Proença et al. (2019). We might speculate then, that the participants' experience of therapy at the WS may have faltered due to the therapist's performance or inexperience to adequately embed the tools and guidelines of her model (most likely a non-TFT approach) enough to hold and contain a client with sexual assault PTSD to the end of her treatment.

The participants' *perception* of the therapist as the professional, and their confounding expectations of therapist expertise, were expressed in their descriptions as confusion about the approach (Mira, Alisa, Helen), conflicting communications (Mira, Alisa, Helen), and silence (Mira, Alisa), and hostility (Alisa). Possible developments in the therapeutic relationship that could explain not challenging the therapist, related to participants presenting with symptoms of PTSD and the psychological challenge this incurred, and also as a means of self-preservation, the therapist might unconsciously silence the participants as a coping mechanism for their own anxiety should they feel attacked or deskilled. However, these factors form the very foundations for creating an imbalance of power in the therapeutic relationship (Ribeiro et al., 2013).

Other research has begun to give attention to the considerable variation in therapeutic outcomes due to therapist effects (Lambert, 1989). Recent studies have established that some therapists achieve better outcomes than others. For example, Saxon Firth and Barkham, (2016) and Zimmermann et al. (2016) found therapist effects have a significant impact on treatment outcomes. Saxon, Firth and Barkham's (2016) study indicated therapists were found to account for around 5–10% of unexplained variance in patient outcomes, with 8–9% being more commonly reported. Similar results are found in different therapy models even after controlling for confounding client variables (Kim, Wampold and Bolt, 2006). Other reports examining therapist effects and outcomes demonstrated that clients who disengage from therapy viewed the therapist as less expert or competent and untrustworthy (Roos and Werbart, 2013). Indeed, Barrett et al. (2008), found that clients' perceptions of therapist expertise, trustworthiness and agreement on goals influenced disengagement. Improved outcomes and reduced disengagement rates are linked to therapists who are more experienced, flexible in relation to treatment, and adjust and adapt to clients' presenting problems (Murdoch, Edwards and Murdoch, 2010). If that is the case, then,

irrespective of TFT and non-TFT models, the more experienced and expert the trauma therapist in her approach to motivate and engage a client enough for the client to want to change, *is* significant for disengagement. The skill of the therapist to develop a relationship with a client that is sustained to the end of the client's therapy treatment, is key to reducing disengagement.

Independent of clients' accounts of therapist effectiveness and disengagement, therapist effect has emerged in research as a contributor to therapeutic outcomes. However, *which* therapist factors might be contributing to these outcomes has yet to be identified (Anderson et al., 2016). Additional research investigating therapist effect on disengagement is crucial for our understanding of the quality of therapists' interpersonal skills and factors that may contribute to disengagement in sexual assault PTSD therapy.

Facilitative Conditions of Therapy

Within the interviews, participants shared their concerns with respect to their therapist facilitating their therapy needs, which included lack of trust in therapy (Mira, Hailey, Alisa), feeling rejected and cut off (Hailey), having no sense of the aim or direction of therapy (Alisa), and feeling judged (Helen). These findings are consistent with Muran and Safran, (2002) research examining facilitative conditions of therapy and citing trust in the therapeutic relationship as the cornerstone of the therapeutic relationship. From the interviews in this study, the participants' accounts expressed many breaches of trust, from being accepted and then rejected by the organisation (Hailey), to the development of power-dyads in themes of abandonment, unclear goals (Mira, Alisa), pacing of therapy, and therapist interventions that assumed resilience (Mira, Helen), rather than assessing the client over the course of therapy and returning regularly to review their therapy goals and tasks.

Therapist interpretation is a technique that introduces a client to a new point of view or awareness that is often theoretically based. An interpretation develops more depth with clients' material and involves communicating suggestions, and *wondering* with the client, with the intention of adding a new understanding or meaning (Ardito, and Rabellino, 2011). In Helen's narrative generally, there was a sense of the

interpretation being unresolved and unprocessed, as she described feeling destabilised by her therapist's premature or late interpretations, perhaps due to the therapist not recognising an under-development of resilience and emotional regulation. Crits-Cristoph and Connolly Gibbons' (2001) study found that therapists using extensive and early interpretations are perceived by clients as unsympathetic and hostile**.**

Reflecting on the theory and practice of mentalisation might also be useful here as a possible interpretation. Mentalising is the capacity to understand the thoughts, feelings and wishes of our own and others' thinking processes (Fonagy et al. 2002). Aspects of the development of PTSD is thought to result from disturbances and fragmentation of one's mentalising skills, as the trauma survivor closes off their mind to the possibility of accessing others' minds as safe and reliable sources of knowledge about how to navigate their environment (in therapy); a process known as epistemic trust. Epistemic trust is an individual's openness to new knowledge as trustworthy and gauging its worth for integration into their own lives. In contrast, epistemic mistrust is characterised by inflexible thinking patterns and a difficulty to learn from social encounters and exchanges (Fonagy and Allison, 2014). These factors may have impacted the participants' ability to be open to their therapists' interpretations.

Timing of a therapist's interpretation may not be aligned to the client's preparedness for the work. For example, clients may not have developed the necessary emotional regulation or resilience to tolerate a new awareness, suggesting a misalignment in the pacing of the therapy sessions. Pacing allows the therapist to attune to the client and monitor the effects of the therapy, allowing the client to slowly develop a new awareness to what is unfolding in the sessions. This is consistent with research by Chouliara et al. (2011), who reported some of the challenges in delivering therapy included difficulties regarding the appropriate timing and depth in trauma-focused work. Pacing in therapy is a collaborative process whereby the therapist aligns to the client's readiness for interventions, balancing challenging a client with appropriate support to facilitate emotional equilibrium for a new awareness. Chouliara et al. (2011) reported that in trauma-focused therapy, it can be difficult to gauge at what point clients reported being directed to trauma work before they felt ready for the challenges this posed. It is evident from some of the participants' experiences that concerns around issues of pacing were felt as therapy not being gauged to their

emotional state of readiness. Rothschild (2000) argues that trauma memories should not be addressed before the client is equipped to manage the distress.

The participants' experiences of the nature of their therapists' facilitative intervention were described in negative terms, such as untrustworthy (Mira, Hailey, Alisa, Helen), lacking in attunement (Mira, Alisa, Helen), and non-collaborative (Mira, Alisa, Helen) in the work of the therapy. The participants' experiences are supported by recent research on therapists' facilitative skills and impact on outcomes by Anderson et al. (2016), which suggests that although some research has emerged for therapist effects as contributing to therapy outcomes, research has yet to identify *which* therapist factors might be contributing to these effects. Some research has indicated therapist relational characteristics might be implicated. Anderson et al.'s (2016) findings suggest that those therapists with the highest facilitative interpersonal skills (FIS) had greater pre–post client outcomes, and higher rates of change across sessions, compared to therapists with low FIS. Moreover, from the first session, high FIS therapists also developed better relationships than low FIS therapists, as well as significant improvements on client-rated relationships (Anderson et al., 2016).

Further research into therapist facilitative effects in establishing those factors that hinder or advance clients' therapy experience will aid in illuminating the reasons for disengagement from therapy for PTSD types.

The Therapeutic Relationship

According to Bordin (1979) the therapeutic relationship consists of three elements, which are: agreement on the goals of therapy, agreement on the tasks of therapy, and the ongoing development of a personal and reciprocal bond. PDT therapy promotes client's self-expression and insight through a variety of techniques that relies entirely on the interpersonal interactions between the therapist and client. The client's sense of safety and trust is central to the therapy process and to the therapist (Ardito and Rabellino, 2011).

The therapeutic relationship is a well-established predictor of engagement and good outcome of psychotherapy, echoed in other research, where findings consistently

show those therapists who accomplish early symptom relief also accomplish a strong relationship, thus reducing the risk of disengagement (Safran, Muran and Eubanks-Carter, 2011). Despite the potential importance of forming a good therapeutic relationship, very little is known about factors that impact its development in PTSD. Several factors, such as clients' avoidance and negative beliefs about others (Safran et al., 1990), may hinder the development of the therapeutic relationships in PTSD treatment. Among those receiving treatment for PTSD, client-rated early-established therapeutic relationship measures predicted better post-treatment PTSD outcomes (Cloitre et al., 2004).

There were clear indications in the participants' therapy experiences of the development of unrepaired ruptures in their therapeutic relationships, evident in their descriptions, including confusing or conflicting messages (Mira), monitoring or questioning trust (Mira, Helen), feeling lost and confused by a lack of goals or focus of therapy (Mira, Alisa), or not understanding the model or approach used (Mira, Alisa, Helen). Research has evidenced that unrepaired ruptures in the therapeutic relationship are a strong indicator of disengagement (Safran, et al., 1990; 2001; 2014). Participants' accounts of therapy indicated many instances of unrepaired therapeutic ruptures, for example, feeling rejected (Mira, Alisa), silenced (Mira, Alisa), abandoned (Mira, Alisa), or that therapist interventions were ill-timed (Alisa, Helen). Ferentz (2015) reports that without the therapist providing an opportunity to neutralise or regain some equilibrium, a rupture can develop in the relationship that remains unrepaired. Recognising issues and timely reparation of therapeutic ruptures can stabilise the relationship, allowing time for clients to pause, consider, process, and then move forward with the sessions at a safe pace (Ferentz, 2015). Research evidence indicates that therapists vary in their ability to recognise and repair ruptures in the therapeutic relationship (Safran and Muran, 2000), but with little data to evidence therapists' process factors for reparation of ruptures it is difficult to substantiate this phenomenon. It is the therapist's responsibility to actively develop rapport, attunement and provide safe enough room to bring the participants' difficulties to light, to reduce tension and discomfort, and to lessen the impact that unprocessed ruptures place on the therapeutic relationship (Safran and Muran, 2000). In relation to ruptures, Safran, Muran and Eubanks-Carter (2011) suggest that therapists seek to understand and empathise with clients' negative feelings about the

therapeutic relationship, and then develop ways to explore and resolve those conflicts. Based on their skills, it is up to the therapist to develop a relationship that can be sustained for the duration of therapy, the quality of which can predict successful outcomes.

In further research, Miller-Bottome (2018) suggests that clients should communicate their distress to the therapist without hesitation, to reduce the mordant effect of unrepaired ruptures on the therapeutic relationship. Their research explored ruptures around clients' attachment patterns, such as those that were insecure, avoidant, or anxious. Miller-Bottome's (2018) study reported that clients with a secure attachment would be able communicate distress or difficulties they were experiencing in therapy, but those clients with anxious or avoidant attachment patterns were potentially unable to communicate their distress effectively or had under-developed coping strategies or resilience to move towards opening such communication with their therapist. This is unsurprising since sexual assault PTSD is a catastrophic interpersonal hindrance, and levels of trust are fragile or non-existent in clients with such presentations. Pearlman and Courtois' (2005) research recognised that those entering therapy with trauma-related attachment disruption as a result of sexual assault, might find developing these skills and attitudes particularly challenging, further reducing resilience in this type of trauma presentation.

As previously mentioned, sexual assault trauma can impact the client's relationships with others, including their therapist. Post assault, the client's interpersonal functioning can become severely compromised. Disrupted attachment beliefs, that is, our core beliefs about self, self in relation to others, and the world in general when entering therapy, will manifest in the relationship with their therapist. The work of the therapist is to create an environment that redefines those attachment beliefs so that the client can regain a sense of safety, trust, esteem, intimacy, and empowerment within the therapeutic relationship (Clark et al., 2015, p. 613). Pearlman and Courtois (2005) affirmed that attachment difficulties associated with sexual assault trauma, can only be understood, and addressed within the context of a therapeutic relationship for "healing that extends beyond resolution of traditional psychiatric symptoms and skill deficits" (Pearlman and Courtois, 2005, p.449). Relational issues that commonly arise in sexual assault PTSD treatment include developing and forming a therapeutic

relationship, managing the therapeutic frame and boundaries, and recognising and working with dissociation and re-enactments.

Trauma, especially of the type arising from interpersonal violence and exploitation, can have a highly negative impact on an individual's capacity to develop and maintain relationships. Attachment patterns and effective therapeutic rupture resolution, as described by Miller-Bottome et al. (2018), are rather more complex for participants presenting with PTSD symptoms, since the psychological distress post sexual assault, will likely impact resilience or regulation stability to develop such a narrative with their therapist. The participants' expressions of ruptures in the therapeutic relationship were felt as negative and hostile, thus potentially repeating previous experiences of hostile relationships by re-enacting a negative relationship with their therapist. In order to conceptualise and understand re-enactments, which can occur inadvertently, often result from the psychological vulnerabilities and defensive strategies that are characteristic of sexual assault survivors (Levy, 1998). Evident from the participants' interviews was a sense of power in the therapy relationship, indicated in hostile transference and countertransference struggles (Alisa), unrepaired or unrecognised therapy ruptures (Mira, Alisa, Helen), and withholding or obstructive dialogues within their therapy (Mira, Alisa).

P4's experience of therapy described avoidance or discomfort of her therapist about P4 working in a similar field. The therapist avoided directly addressing this in therapy with P4, causing all subsequent interactions between them to be slanted, as they carefully navigated not mentioning what they were both thinking. As such, it became impossible to have an authentic, meaningful dialogue. Secondly, and related to P4's work, the therapist assumed (rather than attuned) her resilience to begin the trauma work, that created a rupture in their relationship that remained unworked through by the therapist. This was evident in P4 stating, 'near the end it being said like oh I pushed you harder or something and I was like oh I'm not sure I feel like that's appropriate' (Helen).

Findings from the participants' interviews offer detailed insight into the complexities of forming a therapeutic relationship. Negative transference and countertransference development in the therapeutic relationship was evident across three participants'

therapy experiences. Themes of negative countertransferences in the therapeutic relationship were expressed by participants feeling frustrated (Alisa, Helen), punished by silences (Mira, Alisa), rejected and abandoned (Mira), and therapist hostility (Alisa). Winnicott (1949, p.74) states the therapist's denial of hostility is due to therapy that is adapted to suit the needs of the therapist rather than to the needs of the client. Transference of clients' conflicts, distress and difficulties onto the therapist is a normal part of therapy. In fact, the *work* of the therapist is to contain clients' material and return it to them so that the client has a new insight and introjects this new and modified material or model.

P3's experience of therapy, in which the relationship was overwhelmed with unresolved and unconscious material belonging to the therapist, impacted the entire therapy. Destructive transference-countertransference re-enactments should be made conscious in the process of therapy by the therapist, so that the therapist can become the new and better internal working model for the client. The sense of frustration in P3's accounts of therapy was felt when she stated: 'I was trying to umm separate the feelings that I was having towards the counselling from the feelings that I was having towards the issues I was talking about'. P3 focused her attention in therapy on her therapist's deficiencies as an effective therapist, which had a deleterious effect on the entire therapeutic experience. Curran et al. (2019) affirms that participants remaining preoccupied with the process of therapy and/or their therapist's behaviour, rather than working on the problems which took them to therapy, is a consequence of power in the therapeutic relationship, that is, the participant is unconsciously disempowered by her therapist (Curran et al., 2019).

Unprocessed therapist countertransference material was also evident in P1's therapy, in which she described her final therapy session as, 'she didn't do anything I was kind of waiting for her to give me like ... she would not shake my hand or give me her hand or something so that I can say ok I'll shake hands' (Mira). It could be argued that Mira's sense of her therapist as rejecting might stem from feeling that she had not been able to control the physical contact with the therapist, just like she had not been able to control the physical contact when she was sexually assaulted. In this instance, however, she had the freedom to take charge of the situation by walking away, something she had probably not been able to do when she was sexually assaulted.

Object relations theory (Klein, 1921) seems relevant here and offers further insight within the context of the internal object, that is the therapist, as the significant other with whom P1 is struggling to relate (Greenberg and Mitchell, 1983). The term 'object' can refer to significant others, usually the mother or primary caregiver, though it may also refer to symbolic parts or fragments of a person, such as the mother's breast. In object relations theory, the infant navigates both pain and pleasure from the good breast and the bad breast. The good breast is a channel for sustenance, nourishment, satisfaction, and wellbeing; and the bad breast is unpredictable, painful, denying and panic inducing (Greenberg and Mitchell, 1983). P1, in attempting to defend against possible anxiety of ending therapy, symbolically killed the good breast (object) in order to make the ending tolerable.

Only one report in the literature examined therapists' countertransference. Silveira Júnior et al. (2011) investigated whether therapists' countertransference (CT) at the early stages of treatment for clients with PTSD could predict client disengagement, and their findings indicated there was no association between countertransference in early therapy sessions and treatment outcome. Silveira Júnior et al. (2011) suggested further studies might assess changes in countertransference during treatment, and how such changes could impact treatment outcomes. It is difficult to link therapist countertransference and its influence on participants' disengagement without additional research to further explain this complex phenomenon in therapy.

If a client's dissatisfaction with the therapist or therapy is related to the therapeutic relationship, it will undermine not only the maintenance of the emotional bond and trust, but also the agreement of goals and tasks of therapy (Lambert and Ogles, 2004). Additional research about the potential for therapist effectiveness in relationship and process variances to predict and prevent client disengagement, and those therapist factors that might be related to disengagement, are under investigated in sexual assault PTSD therapy research. The dyadic nature of the therapeutic relationship is seldom acknowledged in TFT research for sexual assault PTSD therapy and disengagement, and there is a paucity of studies that advocate for the concept of healing in the relationship between the therapist and client for sexual assault PTSD (Scott et al., 2009). Psychotherapists are encouraged to turn to EBT and manualised interventions of TFTs for PTSD, in which the therapeutic relationship has become

increasingly decentralised. Of course, psychotherapists must learn to incorporate their approach of therapy in their work with clients, however, approaches for sexual assault PTSD can only really be understood within the relationship (Martin, 2017). The importance of therapist and relational factors for the effectiveness of psychotherapy and their impact on client disengagement in research are essential next steps. Therefore, both theoretical and empirical evidence speak to the importance of establishing a strong therapeutic relationship to facilitate good client outcomes and reduce client disengagement.

Conclusion

This study has illuminated the influences that cause women to disengage from sexual assault PTSD therapy. The accounts shared by the participants emphasised the complex nature of PTSD presentation and the importance of a containing environment within a therapeutic frame, that provides a safe-enough space in which the participants can begin to share their traumatic experience. This was reflected in the participants' interviews, which suggested that they disengaged from PTSD therapy due to unmet therapy expectations that fed into negative therapeutic processes. Examples of negative process included lack of maintenance and quality of the therapeutic relationship, unresolved relationship ruptures, and negative or unprocessed therapist countertransference. These involved a range of unhelpful therapist behaviours, such as over-control, boundary violations and lack of knowledge and/or experience, which in turn were associated with participants feeling disempowered, silenced, or devalued. From the participants' point of view, these were coupled with issues of misuse of power and feeling blamed.

The following chapter outlines the conclusions, including recommendations for future research and the limitations and impact of this study.

Chapter Six

Conclusion

Chapter Overview

This chapter will begin with a summary of the research findings, which will consolidate the original aims of the research with key findings identified during the study. The second section will consider implications for practice followed by contribution to knowledge, future research recommendations and an outline of the limitations of the study. The thesis will conclude with a final words section.

Summary of the Research Findings

This thesis prompted three questions generated from the research findings, which will be summarised along with the related findings.

1. How are therapeutic sessions experienced by women with sexual assault PTSD?

The study revealed that therapeutic sessions for sexual assault PTSD were experienced by the participants within contextual and therapeutic process difficulties, embedded in perceived deficiencies in the development of the therapeutic relationship. This was indicated in the participants' accounts when they described ineffective facilitative conditions of therapy around the management and containment of disclosures; lack of collaboration in goal setting and direction of therapy; lack of attunement to participants' emotional regulation and resilience in preparation for trauma work; inconsistent timing, depth, and pacing of therapeutic interventions, together with unmet client expectations that reinforced negative therapeutic processes.

Examples of negative processes portrayed in the participants' accounts of their therapy experiences included therapist effects linked to unresolved alliance ruptures; negative countertransference dyads or implicit rule setting; the therapist perceived as the professional; lack of therapist experience or limited knowledge of therapeutic process; and therapy focusing on the therapist's agenda rather than the issues that the client brought to therapy. In turn, this was associated with the participants feeling disempowered, silenced, or devalued. From the participants' accounts of their therapy experiences, these were coupled with concerns of an uncomfortable or uncontainable therapeutic relationship, in which the participants were unable to voice their concerns.

2. What are the factors that result in disengagement from therapy, by women who experience sexual assault PTSD?

This study revealed three important factors that resulted in disengagement from therapy by women who experience sexual assault PTSD. Without a therapeutic explanation provided and co-commitment to the treatment actions for their presenting difficulties, women will disengage from sexual assault PTSD therapy. The client and therapist develop in collaboration, the goals of therapy, as well as the tasks (two critical components of the therapeutic relationship), thus creating expectations for therapy that begin with a clear theoretical explanation, agreed upon by the client, as well as the therapeutic activities that are consistent with the explanation, and that the client believes will lead to improved wellbeing. The degree to which the therapy dyad is engaged in collaborative, goal-directed work creates confidence in the client that both she and her therapist are working together, for *her* treatment improvement.

A second factor suggests that if clients do not experience tangible and improved benefits in therapy then they will disengage. Clients need to believe that therapy is going to be beneficial and will reduce or improve their PTSD symptoms. The extent to which clients believe that therapy treatment will be effective or logical has been examined as a predictor of progress in treatment and therapy engagement. If a client begins to doubt the effectiveness of treatment, then their belief in it will diminish, along with their commitment to complete that therapy (Burgoon, 2015). Without the foundations of a therapeutic relationship, however, it was found that credible treatment beliefs alone are unlikely to sustain a client to the end of therapy

(Wampold, 2015). Thus, engagement is two-fold; a model of therapy that is effective in reducing symptoms of PTSD from sexual assault, contained within an effectively maintained therapeutic relationship.

Thirdly, without the development of a well-maintained and sustained therapeutic relationship, clients will disengage from therapy. The accounts shared by the participants in this thesis, indicated that for clients to remain in therapy for sexual assault PTSD, they required a containing, trusting and safe enough therapeutic relationship to enable them to re-experience traumatic memories of sexual assault, aligned to their emotional preparedness. Additionally, participants needed to feel equitable power within the therapeutic relationship, so that they could voice their concerns and know that they would be heard. Therapeutic ruptures, mis-attunement, and negative transference and countertransference processes form part of the work of the therapists' continuity of the therapeutic relationship.

3. What are the implications for the WS for refining therapeutic approaches for the treatment of sexual assault PTSD?

The implications for the WS for refining therapeutic approaches for the treatment of sexual assault PTSD are threefold. Evident in the participants' accounts was a lack of explanation about the goals and direction of therapy by the therapist. As a result, there was no exploration or collaboration with the participants of their treatment goals and/or treatment plan. As such, the participants became confused and lost in their therapy, and without any discernible reduction or management of their PTSD symptoms, they disengaged. The WS does not recommended a specific therapeutic approach be adopted by therapists in their service, and subsequently, therapists can choose from a range of non-TFT holistic and integrative approaches to treat PTSD. Monitoring and marrying therapist skills and experience along with client outcomes, may establish a therapeutic pathway that produces data evidencing positive and negative outcomes, thereby establishing a body of data for therapist approach, skills, and outcomes.

Secondly, it was clear from the participants' experiences of therapy that disengagement was due to dissatisfaction or a feeling that further sessions would not

be beneficial. Without a therapy treatment monitoring system in place, important data reflecting clients' therapy experiences and possible reasons for disengaging are unavailable. Furthermore, if therapist outcome monitoring for their clients' disengagement is also unavailable, there is no possibility of evaluating client outcomes. Recalling clients who have disengaged due to dissatisfaction post therapy is very difficult, further complicating a lack of information for clients' reasons for disengaging. If the reason for disengaging is due to dissatisfaction, clients may be unlikely to engage in or cooperate with reparative communication post therapy, as indeed was the experience of the author of this thesis when recalling clients to volunteer. Additionally, research has shown that clients who disengage from therapy due to dissatisfaction continue to experience significant distress from their original problems having not been met (Swift and Greenberg, 2012). As such, it is crucial for the WS to safeguard disengaged clients beyond the therapy room, introducing a follow-up monitoring system that includes an evaluation of clients' accounts, their reasons for disengaging from therapy, and the opportunity for the client to feel a sense of an ending and of feeling valued.

Thirdly, the participants' account of therapy at the WS reflected a loss of trust in therapy, the therapist, and the organisation, due in the main, to negative alliance process factors. The effect of the therapist on outcomes for clients that disengaged from therapy due to dissatisfaction, is equally as important as the clients' outcomes. How therapists manage disengagement and endings is integral to monitoring outcomes, since they form 50% of the therapeutic dyad. Therapeutic process factors, such as the development of the therapeutic relationship, is rarely investigated for outcomes in research on disengagement, and it is an area that remains largely under researched. Research has informed us repeatedly that the quality of the therapeutic relationship is a strong indicator of engagement or disengagement, which influenced the participants in this study to disengage from therapy.

Implications for Practice

The following implications for practice are outlined in consideration of the participants' shared accounts of their experiences of disengaging from therapy for sexual assault PTSD.

TFT and Non-TFT for PTSD

Several contentious issues have been raised in this thesis concerning the development of psychotherapy treatments for PTSD. To begin with, models for effective, evidence-based TFT for PTSD dominate the research field for PTSD and disengagement. It has been shown that a history of medical model approaches in research, imbued in the language of medicine and empirically validated studies using RCTs, quantitative research and evidenced-based outcomes, have obscured the fact that psychotherapy is an interpersonal process, not a medical procedure. The medical model fails to account for the fact that the vast majority of clients with sexual assault PTSD seek psychotherapy for support, guidance, personal wellbeing, and overall improved quality of life, and not treatment for a mental illness (Elkins, 2009). As such, quantitative research claims of generalisability are inherently flawed as a means of research for effective treatment models for sexual assault PTSD.

Research has suggested that differential types of PTSD presentations require different models of treatment, particularly sexual assault PTSD. The manifold iterations in the DSM-5 for classification of PTSD is testament to this, where measurable PTSD symptoms endorse and validate a criterion. The implication of this is the dissemination of recommended, evidence-based TFT models for PTSD, utilised by clinicians throughout the Western world, within a 'one size fits all' rhetoric of proficiency and superiority, embedded in science and precedence. The client becomes lost in a merging and objectifying criterion of symptoms as their subjective experiences and 'personal meaning', particularly within cross-cultural settings, are not considered of scientific value. The funding of RCTs to continue the search for the most effective medical model to treat PTSD, is shrouded within powerful political and economic ambiguities. Pharmaceutical organisations over-investment in the DSM-5

classification criterion, for example, in a dysfunctional co-dependent relationship, to coin the US phrase, logrolling, irrespective of whether this is conscious bias or not, generates a bias within research (Migone, 2017). Empirical evidence for non-TFT for PTSD being equally as effective in the treatment of PTSD as TFT, is conspicuously unavailable. This bias in research is at the expense of the 'psychological' and 'social' domains in clients' therapy (Alvarez, Pagani and Meucci, 2012). Cognitive treatments decentralise the therapeutic relationship in TFT approaches for PTSD at the cost of the client's interpersonal wellbeing and quality of life, where follow-up or longitudinal research outcomes for sustained reduction of symptoms is scarce. The merits of qualitative research, and the acknowledgement of interpersonal relationships within non-generalising methodological research paradigms representing the experiences of individuals, are undervalued and underinvested. TFT approaches can generate revenue from pharmaceutical organisations, producing evermore research for honing and paring medical model approaches for PTSD. It has been shown that clients with PTSD differ significantly from one another with respect to trauma type, vulnerabilities, onset of trauma symptoms, and significant social factors that affect course and treatment responses. Psychosocial and medical model therapies vary greatly, and clinicians need to consider *all* individual characteristics. TFT might well become the preferred treatment choice for PTSD initially, however, there must be an allowance for effective treatment models in research determined by positive outcomes, drawn from a more balanced overview of effective treatment models for sexual assault PTSD.

Ostensibly in opposite positions, scant qualitative research for non-TFT approaches within current research for sexual assault PTSD and disengagement is disquieting, even though empirical evidence indicates equal effectiveness in their treatment of PTSD. In phenomenological research, and the orientation of this thesis, the client is central, in seeking to understand and describe the universal essence of a phenomenon: the experiences of human beings, within which researchers' preconceived assumptions are suspended. The goal of qualitative research is to observe those behaviours, experiences, and thoughts of individuals, in gaining valuable insight into a phenomenon. Conversely, psychologically and socially orientated non-TFT approaches can be viewed as equally biased, since these models are at the expense of the cognitive domains dominating TFT approaches for PTSD. Research suggests that

non-TFT models are difficult to implement, for example, replication of qualitative research for outcomes that can be applied in clinical practice and in current healthcare systems and services. Application of non-TFT models within research and practice is reliant on the skill and experience of the practitioner, within the therapist's own understanding and working knowledge of the models. Arguably, commonality of TFT and non-TFT approaches for PTSD are heavily reliant on the practitioner's skills, experience and proficiency, affecting outcomes and engagement (Alvarez, Pagani and Meucci, 2012).

Non-TFT treatment approaches for PTSD emphasise the therapeutic relationship, encompassing the three central ideas of collaboration, affective bond, and agreement of treatment goals. One of the most consistent findings evident from this thesis is that a strong therapeutic relationship predicts positive treatment outcomes (Baldwin, Wampold and Imel, 2007). Research increasingly demonstrates that weak or poor alliances are associated with increased disengagement and more especially when measured from the client's perspective (Tryon and Kane, 1993). In this thesis, it was suggested that recognising and attending to reparation of ruptures in the alliance can enhance outcomes and reduce disengagement (Safran et al., 2001). However, the process of recognising and addressing weak alliances is difficult and determined by the effectiveness of the therapist to attend to and repair ruptures. Research evidence suggests that both therapists and clients tended to leave negative affect unsaid, which is especially troubling, since evidence shows that therapists were aware of only a small percentage of what clients withheld, and when outcomes are determined by the therapist to recognise and process material in the relationship, this will impact the therapeutic relationship. Time and again, research suggest that when therapists are aware and nondefensively address ruptures in the therapeutic relationship the alliance improves (Castonguay, Constantino and Holtforth, 2006) along with client engagement.

A memorandum setting out the points of discussion summarised in this chapter is outlined below, in a proposal of good practice for psychotherapists and counsellors in treating adults with single or multiple traumas for sexual assault-type PTSD.

Memorandum of Good Practice – Recommendations

From the research that I have completed I have outlined here a numerical listing of the key clinical points.

1. Therapists might engage with the clients and regularly assess their emotional resilience, endeavouring to attune to the clients' emotional pacing and timing, to navigate a safe dialogue for trauma work.

2. Therapists to move to a more central position in therapy that is focused on clients' needs and work at clients' pace, with an open dialogue about how the therapist is going to work with their trauma material that is collaboratively balanced towards clients' wellbeing.

3. Therapists are encouraged to regularly review and assess their clients' emotional preparedness for trauma work to aid in reminding the client of their original goals for therapy and reassure them of their therapist's commitment to working in collaboration Additionally, it is an opportunity to reassess and adjust therapy goals, if necessary, which can further reassure clients that the therapist is on track and attuned to their needs and goals of therapy.

4. Peer group support for therapists to voice their concerns around disengagement would be beneficial, encouraging collaboration, safety, and containment to begin a dialogue on client disengagement that is honest, transparent and realistic, and without judgemental or criticising repercussions. Additionally, a therapeutic community network or confidential works forum for therapists to connect over shared experiences would also be beneficial.

5. Opportunities in Continuing Professional Development (CPD) for therapists on disengagement and evidence-based practice to assess those skills that therapists bring to their therapy sessions for PTSD that engage and sustain a client to the end of therapy. Additionally, CPD and lessons learned, incorporating ROM and PROMs (addressed fully in the introduction, Chapter, 1) and other evidence-based

effectiveness in measured outcomes such as measures of progress and effectiveness would also be beneficial.

6. Evaluation of therapist effect and processes to be considered when working with survivors of sexual assault, for example, the skills and experience used for successful resolution of therapeutic ruptures and developing and sustaining an alliance to completion of therapy.

Therapists

The participants' accounts highlighted a number of assertions regarding the dissatisfying facilitative conditions of therapy, especially key areas of trust, containment during disclosure, and therapist assumptions of the participants' preparedness for trauma work. Findings from this thesis highlighted the participants' difficulty of sharing traumatic material in uncontainable therapy conditions, suggesting that therapists might engage with the clients and regularly assess their emotional resilience, endeavouring to attune to the clients' emotional pacing and timing, to navigate a safe dialogue for the trauma work.

Participants also shared their confusion or difficulties around the model or approach of the therapist, and the direction and goals of their therapy. From the participant accounts, there was a lack of communication from therapists at the outset about the model of working in trauma therapy, and a lack of clear goals and direction of therapy in collaboration with the client's agreement and needs. It is suggested, therefore, that therapists move to a more central position in therapy that is focused on clients' needs and works at clients' pace, with an open dialogue about how the therapist is going to work with their trauma material that is collaboratively balanced towards clients' wellbeing.

Therapists are encouraged to regularly review and assess their clients' emotional preparedness for trauma work to aid in reminding the client of their original goals for therapy and reassure them of their therapist's commitment to working in collaboration. Additionally, it is an opportunity to reassess and adjust therapy goals, if

necessary, which can further reassure clients that the therapist is on track and attuned to their needs and goals of therapy, which may aid in the client's commitment to remain in therapy.

Professional and Ethical Practice

The participants shared accounts of their therapy that was centred around the therapists' goals for their treatment that was non-collaborative. Unfortunately, this developed an imbalance of power in the therapy relationship which faltered, and the clients disengaged. Peer group support for therapists to voice their concerns around disengagement would be beneficial, encouraging collaboration, safety, and containment to begin a dialogue on client disengagement that is honest, transparent and realistic, and without judgemental or criticising repercussions. Additionally, a therapeutic community network or confidential works forum for therapists to connect over shared experiences would also be beneficial.

Generating opportunities in Continuing Professional Development (CPD) for therapists on disengagement and evidence-based practice might also help. For example, what are those skills that therapists bring to their therapy sessions for PTSD that engage and sustain a client to the end of therapy? How does it feel for therapists when clients disengage? Additionally, CPD and lessons learned, incorporating ROM and PROMs (addressed fully in the introduction, Chapter, 1) and other evidence-based effectiveness in measured outcomes, such as measures of progress and effectiveness, would also be beneficial.

Contribution to Knowledge

This research contributed to the development of knowledge about clients' perspectives of disengaging from PTSD therapy for sexual assault. This study makes an original contribution to the literature for clients who disengaged from therapy for sexual assault PTSD. Few studies have explored the client experience of therapy in detail, and especially from PTSD for sexual assault. Additionally, no existing research

has been found which explores the client perspective of the therapeutic relationship for this PTSD type, and reasons for disengaging.

Several studies have explored disengagement from other psychological therapies and disorders, for example Knox et al.'s (2011) study used clients' accounts and found that reasons for terminating therapy were due to unresolved ruptures and thus termination was unplanned. O'Keeffe et al.'s (2019) study, using clients' accounts of disengagement for treatment of depression in adolescents aged 11-17, found those who disengaged because of dissatisfaction had significantly poorer clinical outcomes compared with those that felt they had benefitted from therapy and disengaged. The authors suggested that existing definitions of disengagement do not capture different types of disengagement when using the generic 'dropout' definition.

No research has been found that investigates clients' perspectives for therapist effect on outcomes and disengagement for sexual assault PTSD. Other studies have explored therapist effect and outcomes, incorporating a range of methods and approaches. Del Re et al.'s (2012) study, for example, indicated that therapist variability in the alliance appears to be more important than client variability for improved client outcomes. The authors added that this relationship remains significant even when simultaneously controlling for several other potential predictors.

Future Research

Therapist Effect

This thesis has established the influence of therapist effect and its impact on treatment outcomes evident in the participants' experiences of therapy. Future research to explore, for example, the therapist effect on outcomes, to develop and sustain an alliance would be helpful in the field of client disengagement across all disorders and treatment approaches (Safran and Muran, 2000). In contrast to continued efforts by researchers to develop effective models of treatment for PTSD, which dominated the literature review for this thesis, there has been relatively little research into the variability between therapists providing therapy in TFT and non-TFT, despite therapists' utilisation of such models, training, skills, and experiences in clinical

settings. The concentrated efforts in research to develop effective EBT for PTSD have further highlighted the need for research in therapist effect; different therapists have different capacities, skills and experience to sustain a client to the end of her treatment.

Safran et al. (1990) reported that therapy that was more closely associated with the successful resolution of ruptures in the alliance achieved positive outcomes. Thus, it seems imperative that research turn its focus to an examination of therapists' skills and evaluation of effective reparation of therapeutic ruptures *during* treatment. If such ruptures can be addressed during therapy, it is possible that future research for reduced disengagement rates may begin to emerge.

Moreover, future research could pay special attention to the comparison of clients' and therapists' evaluation of the therapeutic relationship since these have been found to differ; research evidence suggested that the client's evaluation is a more reliable predictor of the outcome of psychotherapy (Ardito and Rabellino, 2011). Obtaining regular structured feedback about, for example, symptom changes, may benefit therapists' ability to identify client dissatisfaction early in the treatment, which could reduce disengagement rates. Additionally, implementing and monitoring treatment responses would capture accounts from clients before they disengaged (Lambert, 2015), and monitoring such responses at regular intervals throughout the course of therapy, would act as a measure of evidence-based practice for treatment outcomes, which are crucial for understanding client disengagement (Brattland, et al., 2018). Such a system would promote evidence-based practice and quality and improvement measures to hold therapists accountable for clinical outcomes with their clients (Imel et al., 2015).

Methodological Challenges

Many studies have examined disengagement and early therapy withdrawal by clients. However, methodological problems exist in the range of definitions investigators use for disengagement. Even though most studies have defined disengagement as leaving therapy before a specified number of sessions, the actual definition varies across and

within studies, which can obscure definitive answers; parameters for definitions of disengagement are often defined in individual studies by researchers that are dependent on the study design and methods used (Barrett et al., 2008). Future research for disengagement might look to develop a classification criterion for disengagement to operationalise a definition that may lead to more consistent findings within the literature and provide more clinically useful findings, possibly generating improved outcomes for therapy disengagement.

Research examining disengagement for different trauma types and effects on outcomes has begun to emerge in the field. Early indications from research examining post-traumatic symptoms indicate negative outcomes can differ as a function of the type of trauma experienced. For example, research examining PTSD symptom improvement in different groups of trauma survivors has found that PTSD symptoms are more prevalent in sexual assault survivors than in other types of traumas (Shakespeare-Finch and Armstrong, 2010).

Given the findings in this study, and the participants' experiences of adverse therapeutic processes and outcomes in their therapy experience, another strategy to overcome the methodological challenge is to draw on qualitative evidence from client-reported outcomes. Few studies have investigated clients' first-hand experiences of disengaging from PTSD therapy, and fewer still for different types of PTSD presentations and disengagement. Qualitative methods are ideal for eliciting the perspectives of those being studied, allowing individuals to speak in their own voice, rather than conforming to categories and terms imposed on them, as used, for example, in quantitative methods. Exploring participant perspectives in qualitative methods, enhances the validity of data being collected because it enables the investigator to compare their own perception of reality with the perception of those who are being studied, as in phenomenology and the focus of this thesis (Palinkas et al. 2015).

Finally, greater consideration in the use of qualitative research methods is needed to explore the influence of race, culture, socialisation, and wellbeing for client perceptions of mental health and its treatments. Studies that use interviews with potential and current clients offer a wealth of information about engagement and

disengagement from treatment that may not be readily apparent to researchers. Similarly, interviews with therapists might offer unique perspectives on why clients disengage from PTSD therapy. Quantitative research studies might be designed to more specifically assess the needs, perceptions, and expectations of clients in order that issues of therapeutic approach and the therapeutic relationship might be recognised and addressed within the treatment protocol. Regardless of the direction of research, focusing on reducing disengagement in sexual assault PTSD to enhance the effectiveness of existing treatments and improving therapy outcome is imperative, over and above continuing the focus on RCTs for the development of evermore new treatments to adapt to evermore presenting PTSD symptoms.

The therapeutic relationship process and the potential challenges that therapists may face when working with sexual assault survivors are also under-researched. The experiences of the participants in this study provided evidence to acknowledge the under-researched aspects of therapist effect and processes to be considered when working with survivors of sexual assault. Qualitative research reports drawing on clients' *and* therapists' clinical outcomes and reasons for disengagement will generate valuable empirical and theoretical evidence-based practice outcomes for mental health services.

Limitations of the Study

A limitation of the study in the analysis was in the development of the interview questions. The epistemological underpinning of IPA requires the development of questions to be directed from a phenomenological position, since the researcher was trying to make sense of the participants' understanding of their experiences. However, the questions for this thesis, though exploratory, were too leading, which could have undermined the methodology and the analysis.

The limited information sources from a review of the existing literature and gaps in the field restricted this study when drawing upon previous research. For example, despite finding compelling evidence for disengagement, this was limited in the main to TFT approaches for the treatment of PTSD, and much of the literature was from a

quantitative methodology that made comparative arguments difficult. Additionally, the research field for PTSD therapy and disengagement is lacking in classification or criterion for type of PTSD and disengagement rates. For example, PTSD as a consequence of war, and PTSD as a consequence of sexual assault, are categories that have different pathologies and complexities of symptoms that may require different trauma-informed approaches. Consequently, this resulted in a lack of evidence underpinning this area of research.

Reflexivity and bracketing played an important role during the analysis of the participants' transcripts. The participants' extracts were drawn directly from their interviews; however, it would be impossible to truly avoid an element of subjectivity to enter into the study due to interviewer/investigator influence during the analysis. The participants were involved in member checking, as were academic peers, which controlled for researcher bias to a large extent. In the main, this research adapted to the limitation to meet the credibility indicators recommended for qualitative research for validation (Smith, Flowers and Larkin, 2009)

Reflective and Self-Reflexive Summary

The research process and my learning developed concurrently, such that my beliefs, preconceptions and assumptions that underwrite this thesis came under scrutiny. In the main it was related to shifting perspectives: like concentric circles, with each circle representing a different level of learning that informed the common center, me; the author. Thus, me, the WS and disengagement, mental health services in the UK and disengagement, mental health in the Western world and disengagement: illuminating and constructing how I came to know what I did not know I did not know. Looking back over the past six years (8 years including recruiting participants for the project), I can see my inexperience and naivety, when the service manager at the WS handed me a small audit and shared her concerns about client disengagement at the WS. I could also see, what I could not see then: an all-too-ambitious undertaking and an ethical responsibility that became increasingly significant in evaluating my self-reflexive development. Research is about perspectives, and reflexivity is a thoughtful perspective that attempts to evaluate and extend my understanding of a subject of inquiry and that of the readers understanding and

perspectives (Cousin, 2013). A note that I scribbled on Helen's (P4) transcript in the early stages of analysis, for example, in which she felt that it was not appropriate for the therapist to 'push her harder' (lines, 331-332), I had written 'therapist's expectations?', because that was how I interpreted it, but it also resonated with me, and made me feel discomforted. I had experienced something similar with a client, and after some reflection concluded that I too was the reason the client disengaged from her therapy with me – due to *my* expectations that the client felt unable to meet. I came to realise the multifaceted, multi-layered complexity of the research undertaking, and underestimated how the outcomes were going to impact me, the community in which I worked, and the ripple effects of a client disengaging without systems or protocols in place, or an infrastructure for organisational process to enable her, or me, to voice that experience safely.

Reflexivity is a practice that informs both public and personal inquiry in research. Those two things run adjacent to each other in terms of how it framed my thinking and perspectives and what that brought to this inquiry. The framework, paradigms and discourses that shape this thesis have illuminated and confounded many of the beliefs and assumptions that I started with. I began this research journey in a small women's service in London, to inquire why clients disengaged from therapy for PTSD before completing all of their therapy sessions – a journey that extended to mental health services and contemporary thinking and treatment approaches in the Western world (and further). My thinking and knowledge along that journey became woven in to the experiences that I brought to this research, as an individual, as a therapist and as a novice researcher.

Final Words

This thesis aimed to inform the direction taken of existing and current psychological therapies research for disengagement which, to date, is saturated with quantitative methodologies and recommended 'gold standard' TFT approaches for PTSD treatment, regardless of differential trauma types, and of the outcomes that continue to produce high rates of disengagement.

The participants' experiences of disengaging from sexual assault PTSD therapy have provided renewed insight into those influences that persuade a client to disengage from treatment before any noticeable improvement in their mental health and wellbeing. Each of the four women in this study shared their experience of a therapy that failed them; a common connecting theme was their initial courage to take a step towards a healing relationship, that became another source of disempowerment.

Despite a large body of research literature on client disengagement from therapeutic treatments, rates of disengagement remain high across all approaches, for all treatments and in all services. Research on client disengagement has for very many years focused on retrospective data to examine and predict client disengagement, that keeps its sight firmly fixed on the client to determine reasons for disengagement.

Research in this thesis has highlighted that TFT approaches to treat PTSD, echo similar rates of disengagement from these specialist therapies, as do therapy approaches generally for PTSD. Conflicting data and unreliable, inconsistent outcomes form the basis of research on TFT approaches for PTSD, with mixed results on their effectiveness and symptom relief. Despite a growing consensus that TFT approaches represent the most effective way of treating PTSD, research has emphasised that these approaches are not always feasible to deliver, and a shortage of suitably qualified therapists to provide such specialist treatments remains challenging for services. Moreover, it was emphasised in this thesis that therapists lack confidence in the use of TFT approaches due to possible negative outcomes and disengagement.

Continuing to research TFT models for PTSD without attending to therapist effects and the centrality of the therapeutic relationship will likely bring the same results for disengagement. Within non-TFT approaches for treating PTSD, the scant amount of empirical research continues a long-held focus on client deficits for disengagement. Therapeutic outcomes from qualitative research that measure for example, therapist effect, therapeutic relationship, and successful rupture resolution, is the next sensible step, to redress the imbalance of research available for disengagement from sexual assault PTSD in non-TFT approaches.

It was apparent from the literature review that research using actual client accounts of disengagement from PTSD therapy is limited. This thesis fills a gap in the literature by directly asking participants why they disengaged from sexual assault PTSD therapy, thereby giving clients a platform from which to voice their concerns, reasons for disengaging and their decision-making processes. Further research into those therapeutic process influences that induce clients to disengage from therapy is crucial for advancing our understanding of client-therapist patterns of relating, the interpersonal and attachment patterns of the therapist, and the skills and experience the therapists bring to trauma therapy that sustains a client to completion of therapy treatment. The therapeutic relationship is a collaborative dyad: two individuals bringing their relational history and experiences to therapy. Only measuring one of those individuals for outcomes of disengagement is detrimental to clients' mental health, wellbeing, and quality of life.

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Appendix 1

TFT and Non-TFT Approaches

Trauma Focused Therapies (TFT)		
CBT	Cognitive Behavioural Therapy	Cognitive Behavioural Therapy (CBT) uses principles of learning and conditioning to treat disorders and includes components from both behavioural and cognitive therapy. In CBT, components such as exposure, cognitive restructuring, and various coping skills have been used either alone or in combination with one another to treat PTSD. Most forms of CBT consist of a minimum of 8 to 12 weekly sessions lasting 60 to 90 minutes. CBT can be administered either as group or individual therapy.
Cognitive Restructuring	Cognitive Restructuring	Based on the theory that the interpretation of the event, rather than the event itself, determines an individual's mood. It aims to facilitate relearning thoughts and beliefs generated from a traumatic event, increase awareness of dysfunctional trauma-related thoughts, and correct or replace those thoughts with more adaptive and/or rational cognitions. Cognitive restructuring generally takes place over 8 to 12 sessions of 60 to 90 minutes.
CPT	Cognitive Processing Therapy	A form of cognitive behaviour therapy originally used with victims of rape or sexual trauma and later applied to those with posttraumatic stress disorder resulting from any trauma. CPT emphasizes cognitive strategies to help people alter erroneous thinking that has emerged because of a traumatic event. Usually, five to 20 sessions.
CT	Cognitive Therapy	Cognitive restructuring is based on the theory that the interpretation of the event, rather than the event itself, determines an individual's mood. It aims to facilitate relearning thoughts and beliefs generated from a traumatic event, increase awareness of dysfunctional trauma-related thoughts, and correct or replace those thoughts with more adaptive and/or rational cognitions.

		Cognitive restructuring generally takes place over 8 to 12 sessions of 60 to 90 minutes.
DET	Dialogical Exposure Therapy	Integrates CBT techniques with gestalt therapy components and dialogical aspects of the therapeutic relationship and process. DET typically proceeds in four stages: safety, stability, confrontation, and integration. While the first two stages are quite similar to CBT, the confrontation stage instead focuses on finding a way to preserve one's self-processes while in dialogue with the imagined perpetrator/trauma experience. The final stage of integration involves accepting the experience and the changes resulting from it by integrating it into one's life story, preventing relapse. Duration is flexible and can be up to 20 sessions.
EBT	Evidence Based Treatment	Evidence-based treatment refers to treatment that is backed by scientific evidence. That is, studies have been conducted and extensive research has been documented on a particular treatment, and it has proven to be successful.
EMDR	Eye Movement Desensitisation and Reprocessing	Combines imaginal exposure with the concurrent induction of saccadic eye movements that are believed to help reprogram brain function so that the emotional impact of trauma can be resolved. In the EMDR process, the client is instructed to imagine a traumatic memory, engage in negative cognition, and then articulate an incompatible positive cognition (e.g., personal worth). The clinician asks the client to contemplate memory while focusing on rapid movement of clinicians' fingers. Although earlier versions of EMDR consisted of one to three sessions, current standards consist of 8 to 12 90-minute weekly sessions.
EST	Empirically Supported Treatment	Empirically Supported Treatment refers to specific psychological treatments for a specific population/disorder (e.g., individuals with PTSD) that have been proven effective in controlled research.
FAP	Functional Analytic Psychotherapy	A contextual, behavioural, relational approach to psychotherapy in which therapists focus on what happens in session between the client and therapist to shape the interpersonal behaviours, emotional awareness, and self-expression necessary for clients to create and maintain close relationships and to live meaningful lives.

		Often conjoined within the context of other models of trauma-informed treatment, for example CBT. Up to 12 sessions is usual.
IE	Interoceptive Exposure or Imaginal Exposure	A type of exposure therapy used for treating individuals with anxiety disorders (e.g., phobias, obsessive-compulsive disorder, posttraumatic stress disorder). Vivid imagery evoked through speech is used by the therapist to expose the client mentally to an anxiety-evoking stimulus. Usually 8-15 sessions.
MCT	Metacognitive Therapy	A psychotherapy focused on modifying metacognitive beliefs that perpetuate states of worry, rumination, and attention fixation. The goal is to discover what clients believe about their own thoughts and about how their mind works (called metacognitive beliefs), then to show the client how these beliefs lead to unhelpful responses to thoughts that serve to unintentionally prolong or worsen symptoms, and finally to provide alternative ways of responding to thoughts to allow a reduction of symptoms. Between 8–12 sessions.
NE	Narrative Exposure	A short-term psychotherapy used for the treatment of post-traumatic stress disorder and other trauma-related mental disorders. It creates a written account of the traumatic experiences of a client or group of clients, with the aim of recapturing self-respect and acknowledging the client's value. Usually, four to 10 sessions.
PC	Progressive Counting	PC is a psychotherapy procedure for resolving trauma or loss memories via memory reconsolidation. Briefly, it entails guiding the client to imagine a movie of the distressing memory, from beginning to end, while the therapist counts aloud first from 1-10, then 1-20, then 1-30, etc., to a maximum of 100. As the distress level goes down, the movies get shorter. This continues until no memory-related distress remains. PC can be done as a stand-alone treatment or within the context of a comprehensive phase model of trauma-informed treatment. Up to 12 sessions.
PE	Prolonged Exposure	A theoretically based treatment for chronic post-traumatic stress disorder (PTSD) and related depression, anxiety, and anger. Focus is on

		confronting the harmless cues/triggers of trauma/stress in order to unpair them from the feelings of anxiety and stress. Usually 8-15 sessions.
RCT	Randomised Controlled Trial	An experimental design in which clients are randomly assigned to a group that will receive an experimental treatment, such as a new drug, or to one that will receive a comparison treatment, a standard-of-care treatment, or a placebo.
SIT	Stress Inoculation Therapy (also called Stress Inoculation Training)	A four-phase training program for stress management often used in CBT. Phase 1 entails the identification of one's reactions to stress and their effects on functioning and psychological well-being; Phase 2 involves learning relaxation and self-regulation techniques; Phase 3 consists of learning coping self-statements and Phase 4 involves assisted progression through a series of increasingly stressful situations using imagery, video, role playing, and real-life situations until the individual is eventually able to cope with the original stress-inducing situation or event. In most instances, SIT consists of 8 to 15 sessions, plus booster and follow-up sessions, conducted over a 3-to-12-month period.
TI-MBSR	Trauma-Informed Model of Mindfulness-Based Stress Reduction	Tailored by pairing mindfulness practices with trauma-specific psychoeducation to facilitate awareness of and exposure to conditioned trauma responses, without avoidance or reactivity to those experiences.

Non-Trauma Focused Therapies (Non-TFT)		
Dialogical Therapy	Dialogical Therapy (also called dialogical philosophy and dialogical theory)	In Martin Buber's dialogical philosophy, when one views another person as an object, an I-It relationship is manifested. Such a relationship is no longer dialogical, but monological: a relation only with oneself. An I –It relationship implies that one speaks *to* the object, rather than *with* the object. A dialogical relationship can only exist in a subject-subject relationship, meaning in an inter-subjective relationship: a relationship which exists between individuals who view each other as subjects. In the I-It relationship, an individual treats things, people, etc., as objects to be used and experienced. Essentially, this form of objectivity means that the individual relates

		to the world in terms of how objects can serve its own interests. Human relationships swing like a pendulum between I-It and I-Thou relationships, and genuine I-Thou relationships are rare. Buber argues that I-It relations devaluate, isolate and dehumanise human existence. In contrast, an I-Thou relationship stresses the mutual, holistic existence of two beings. It becomes a concrete encounter, because these beings meet one another in their authentic existence, without any qualification or objectification of one another. http://kaaretorgnypettersen.blogspot.com/2012/03/bubers-dialogical-philosophy.html
Emotion Regulation Skills Training	Emotion Regulation Skills Training (also called Emotional Regulation Therapy)	The ability of an individual to modulate an emotion or set of emotions. Explicit emotion regulation requires conscious monitoring, using techniques such as learning to construe situations differently to manage them better, changing the target of an emotion (e.g., anger) in a way likely to produce a more positive outcome, and recognising how different behaviours can be used in the service of a given emotional state. Emotion regulation skills training is often conjoined with other TFT therapy interventions for PTSD.
Gestalt Therapy	Gestalt Therapy	A form of psychotherapy which emphasises personal responsibility and focuses on the individual's experience in the present moment, the therapist–client relationship, the environmental and social contexts of a person's life, and the self-regulating adjustments people make because of their overall situation. Therapy sessions can be short-term or long-term, depending upon the client's needs.
IPT	Interpersonal Therapy	A time-limited, dynamically informed psychotherapy that aims to improve interpersonal functioning. Focuses specifically on interpersonal relationships and aims to help clients either improve their interpersonal relationships or change their expectations about them. In addition, it aims to help clients improve their social support so they can better manage their current interpersonal distress. Interpersonal therapy generally requires 10 to 20 weekly sessions in the acute phase followed by a time-unlimited maintenance phase.
MBSR	Mindfulness Based Stress Reduction	An eight-week evidence-based program that offers secular, intensive mindfulness training to assist people with stress, anxiety, depression, and pain. MBSR uses a combination of mindfulness meditation, body awareness, yoga, and exploration of patterns of behaviour, thinking, feeling and action. Mindfulness can reduce suffering or distress and increase well-being. Mindfulness meditation

		is a method by which attention skills are cultivated, emotional regulation is developed, and rumination and worry are significantly reduced. MBSR has its roots in Buddhist wisdom and teachings.
PCT	Person Centred Therapy (also called Present-centred and Client-centred Therapy)	A form of psychotherapy in which an orderly process of client self-discovery and actualization occurs in response to the therapist's consistent empathic understanding of, acceptance of, and respect for the client's frame of reference. The therapist establishes an encouraging atmosphere but avoids giving advice, offering interpretations, or engaging in other actions to actively direct the therapeutic process. Therapy sessions can be short-term or long-term, depending upon the client's needs.
PDT	Psychodynamic Therapy	Explores the psychological meaning of a traumatic event. The goal is to bring unconscious memories into conscious awareness so that PTSD symptoms are reduced. The therapy presumes the PTSD symptoms are the result of the unconscious memories. Psychodynamic therapy for PTSD would consist of weekly to biweekly sessions over a period of several months to an indefinite period of time.
Resilience	Resilience (also called psychological resilience)	Resilience is the process and outcome of successfully adapting to difficult or challenging life experiences, especially through mental, emotional, and behavioural flexibility and adjustment to external and internal demands. A number of factors contribute to how well people adapt to adversities, predominant among them (a) the ways in which individuals view and engage with the world, (b) the availability and quality of social resources, and (c) specific coping strategies. Psychological research demonstrates that the resources and skills associated with more positive adaptation (i.e., greater resilience) can be cultivated and practiced.
RT	Relaxation Therapy (also called Therapeutic Relaxation)	Use of muscle-relaxation techniques to aid in the treatment of emotional tension. RT is often conjoined with other TFT therapy interventions for PTSD.
Yoga	Yoga	Hindu philosophy and practical teaching for prescribed mental discipline and physical exercises. Yoga exercises, including regulation of breathing and the adaptation of bodily postures are used as a means of releasing tension and redirecting energy (i.e., prana) and achieving a state of self-control, physical and mental relaxation, and finally deep contemplation. Often conjoined with other TFT therapy interventions for PTSD.

Appendix 2

Psychodynamic Therapy (PDT)
Definition of Terms

Term	Definition
Attachment	John Bowlby's (1969) evolutionary theory of attachment suggests that children come into the world biologically pre-programmed to form attachments with others, because this will help them to survive. A child has an innate (i.e. inborn) need to attach to one main attachment figure. There are four different attachment types: secure, avoidant, anxious, and disorganised. Bowlby hypothesised that attachment style informs people's relationships in adulthood. Attachment styles reflect patterns of regulation associated with internal working models (i.e., cognitive-affective representations of the self, the others and the relationship between the self and the others) that become automated over time, leading to a stable, introjected relational style in adulthood that operates largely outside of conscious awareness (Bowlby, 1969])
Attunement	1. The matching of affect between infant and parent or caregiver to create emotional synchrony. The parent's response can take the form of mirroring (e.g., returning an infant's smile) or be cross-modal (e.g., a vocal response "uh oh" to the infant's dropping something on the floor). Attunement communicates to the infant that the parent can understand and share the infant's feelings. This is replicated by the therapist in the development of the therapeutic alliance. For a full definition see https://dictionary.apa.org/attunement. 2. Attunement is described by Daniel Stern as the immediate recasting of the emotional-behavioural state of one person by another person, using affect emphasised behaviours. Attunement is not just an imitation of the behaviour, but more an attempt to reflect back the emotion and feelings projected by the infant (client), thereby creating a connection between the two (Stern et al., (1985).

Compulsion to repeat (also Repetition Compulsion)	Compulsion to repeat acts as a resistance to therapeutic change since the goal of therapy is not to repeat but to remember the trauma and to see its relation to present behaviour.
Conscious	The upper level of mental life of which the person is aware as contrasted with unconscious processes.
Containment	In object relations theory, the therapist aids growth and alleviates anxieties by acting as a 'container,' or 'holding environment,' for projected aspects of the client's psyche. The therapist metaphorically holds and soothes the client by helping to reduce any anxiety to tolerable levels.
Countertransference	The therapist's unconscious (and often conscious) reactions to the client and to the client's transference. These thoughts and feelings are based on the therapist's own psychological needs and conflicts and may be unexpressed or revealed through conscious responses to patient behaviour. The term was originally used to describe this process in psychoanalysis but has since become part of the common lexicon in other forms of psychodynamic psychotherapy. It may serve as a source of insight into the client's effect on other people. In either case, the therapist must be aware of, and analyse, countertransference so that it can be used productively within the therapeutic process.
Defense mechanism	An unconscious reaction pattern employed by the ego to protect itself from the anxiety that arises from psychic conflict. Such mechanisms range from mature to immature, depending on how much they distort reality.
Empathy	Understanding a person from his or her frame of reference rather than one's own, or vicariously experiencing that person's feelings, perceptions, and thoughts. In psychotherapy, therapist empathy for the client can be a path to comprehension of the client's cognitions, affects, motivations, or behaviours.
Enactment	1. the acting out of an important life event rather than expressing it in words. 2. in some forms of psychoanalytic psychotherapy, the patient's reliving of past relationships in the transference relationship with the therapist and, conversely, the therapist's move away from active neutrality to unwittingly intertwine personal issues into symbolic interactions with the patient

	(a countertransference phenomenon). Attunement to the relational patterns that emerge in this therapeutic relationship offers the therapist an opportunity to help the patient acknowledge and work through similar patterns in the patient's relationships with others.
Holding environment	1. in object relations theory (Donald Winnicott (1896–1971)), that aspect of the mother experienced by the infant as the environment that literally—and figuratively, by demonstrating highly focused attention and concern—holds him or her comfortingly during calm states. This is in contrast to the mother who is experienced as the object of the infant's excited states. 2. in psychoanalysis, any therapeutic space that allows an emotionally fragile or insecure person to deal with affects that might potentially be overwhelming. https://dictionary.apa.org/holding-environment
Interpersonal relationships	1. The connections and interactions, especially ones that are socially and emotionally significant, between two or more people. 2. The pattern or patterns observable in an individual's dealings with other people.
Interpersonal relatedness	Refers to the need to establish close, stable, nurturing, and protective relationships (Blatt, 1974).
Interpretation	Interpretation is an explanation by the therapist in terms that are meaningful to the client of the client's issues, behaviours, or feelings. Interpretation typically is made along the lines of the conceptual framework or dynamic model of the particular therapy. In psychoanalysis, for example, the therapist uses the constructs of psychoanalytic theory to interpret the client's early experiences, dreams, defenses, and resistance. Although interpretation exists to some extent in almost any form of therapy, it is a critical procedural step in psychoanalysis and in other forms of psychodynamic psychotherapy.

Intersubjectivity	The sharing of subjective experience between two or more people. Intersubjectivity is seen as essential to language and the production of social meaning. The term is often applied to the relationship between a therapist and a client.
Introjection	1. a process in which an individual unconsciously incorporates aspects of external reality into the self, particularly the attitudes, values, and qualities of another person or a part of another person's personality. Introjection may occur, for example, in the mourning process for a loved one. 2. in psychoanalytic theory, the process of absorbing the qualities of an external object into the psyche in the form of an internal object or mental representation (i.e., an introject), which then has an influence on behaviour. This process is posited to be a normal part of development, as when introjection of parental values and attitudes forms the superego, but it may also be used as a defense mechanism in situations that arouse anxiety. https://dictionary.apa.org/introjection
Mentalisation	The ability to understand one's own and others' mental states, thereby comprehending one's own and others' intentions and affects. It has been theorised that this ability is a component of healthy personality development and is achieved through a child's secure attachment to the parent. Mentalisation-based treatment (MBT) is a psychodynamically oriented psychotherapy that was developed specifically to address mentalisation deficits such as impulse control and affect regulation, and to improve interpersonal functioning.
Object Relations Theory	Theory that views the need to relate to objects as more central to personality organisation and motivation than the vicissitudes of the instincts. These theories developed from and in reaction to classic Freudian theories of psychoanalysis and biological drives. Object relations theory places emphasis on the importance of consistent patterns of interpersonal relationships.
Parallel process	Parallel process phenomena have been described from a variety of perspectives. While there has been variance regarding points of emphasis, the role of unconscious

	identification provides a common conceptual thread within each formulation.
Re-enactment	In some forms of psychotherapy, the process of reliving traumatic events and past experiences and relationships while also reexperiencing the original emotions associated with them.
Resilience	The process and outcome of successfully adapting to difficult or challenging life experiences, especially through mental, emotional, and behavioural flexibility and adjustment to external and internal demands.
Rupture	"A rupture is a deterioration in the therapeutic alliance, manifested by a disagreement between the patient and therapist on treatment goals, a lack of collaboration on therapeutic tasks, or a strain in their emotional bond" (Eubanks, Muran, and Safran, 2018).
Self-regulation	The bringing of oneself, emotional self, or itself into a state of order, method, or uniformity.
Somatic	Describing, relating to, or arising in the body rather than from the mind.
Transference	A client projects onto the therapist those unconscious feelings and wishes originally directed toward important individuals, such as parents, in the client's childhood. It is posited that this process brings repressed material to the surface where it can be reexperienced, studied, and worked through with the therapist to discover the sources of a client's current difficulties and to alleviate their harmful effects.
Trigger	To cause an intense and usually negative emotional reaction in someone.
Therapeutic Alliance	Sometimes called the working alliance, the therapeutic alliance is the trust between patient and therapist that allows them to work together effectively. The therapeutic alliance is the cooperative working relationship between client and therapist, considered by many to be an essential aspect of successful therapy. Derived from the concept of the psychoanalytic working alliance, the therapeutic alliance comprises bonds, goals, and tasks. Bonds are constituted by the core conditions of therapy, the client's attitude toward the therapist, and the therapist's style of relating to the client; goals are the mutually negotiated, understood, agreed upon, and regularly reviewed aims of the therapy; and tasks are the activities carried out by both client and therapist.

Unconscious	The region of the psyche containing memories, emotional conflicts, wishes, and repressed impulses that are not directly accessible to awareness but that have dynamic effects on thought and behaviour.

Appendix 3

Psychodynamic Therapy (PDT) Defense Mechanisms

Definition of Terms

Term	Definition
Acting out	The development of detrimental behaviours that distract attention and energy away from other stressors. 1. The behavioural expression of emotions that serves to relieve tension associated with these emotions or to communicate them in a disguised, or indirect, way to others. Such behaviours may include arguing, fighting, stealing, threatening, or throwing tantrums. 2. In psychoanalytic theory, re-enactment of past events as an expression of unconscious emotional conflicts, feelings, or desires—often sexual or aggressive—with no conscious awareness of the origin or meaning of these behaviours.
Avoidance	Dismissing thoughts or feelings that are uncomfortable or keeping away from people, places, or situations associated with uncomfortable thoughts or feelings. This defense mechanism may be present in post-traumatic stress disorder, where one avoids the location of a traumatic motor vehicle accident or avoids driving completely.
Denial	Dismissing external reality and instead focusing on internal explanations or fallacies and thereby avoiding the uncomfortable reality of a situation. This defense mechanism may be present in someone who continues to shop for expensive designer clothes despite being in serious financial debt.
Dissociation	Dissociated state is a reaction to a traumatic event in which the individual splits the components of the event into those that can be faced in the present and those that are too harmful to process. https://dictionary.apa.org/dissociated-state
Flight into health	In psychotherapy, a sudden claim by a client to be fully recovered and in no further need of help is often interpreted as a defensive

	reaction to attending therapy. Psychoanalytic theory interprets the flight into health as an unconscious defense mechanism. Also called transference cure, and transference remission. For a full definition of flight into health see https://dictionary.apa.org/flight-into-health.
Id, ego, and superego	Three concepts in psychoanalytic theory describing distinct, interacting agents in the psychic apparatus, defined by Sigmund Freud as a model for personality development. The three agents are theoretical constructs that describe the activities and interactions of the mental life of a person. In the ego psychology model of the psyche, the id is the set of uncoordinated instinctual desires; the superego plays the critical and moralising role; and the ego is the organised, realistic agent that mediates between the instinctual desires of the id and the critical superego. The key to a healthy personality is a balance between the id, the ego, and the superego. According to Freud, if the ego can adequately mediate between the demands of reality, the id, and the super-ego; a healthy personality emerges. Imbalance between these elements would lead to maladaptive personality development.
Identification	The internalisation or reproduction of behaviours observed in others, such as a child developing the behaviour of his or her parents without conscious realisation of this process. Identification is also known as introjection.
Intellectualisation	The development of patterns of excessive thinking or over-analysing, which may increase the distance from one's emotions. For example, someone diagnosed with a terminal illness does not show emotion after the diagnosis is given but instead starts to research every source they can find about the illness.

Introjection	In psychoanalytic theory, the process of absorbing the qualities of an external object into the psyche in the form of an internal object or mental representation (i.e., an introject), which then has an influence on behaviour. This process is posited to be a normal part of development, as when introjection of parental values and attitudes forms the superego, but it may also be used as a defense mechanism in situations that arouse anxiety. https://dictionary.apa.org/introjection
Projection	Attributing one's own maladaptive inner impulses to someone else. For example, someone who commits an episode of infidelity in their marriage may then accuse their partner of infidelity or may become more suspicious of their partner.
Rationalisation	The justification of one's behaviour through attempts at a rational explanation. This defense mechanism may be present in someone who steals money but feels justified in doing so because they needed the money more than the person from whom they stole.
Regression	Adapting one's behaviour to earlier levels of psychosocial development. For example, a stressful event may cause an individual to regress to bed-wetting after they have already outgrown this behaviour.
Repression	Unconsciously blocking ideas or impulses that are undesirable. This defense mechanism may be present in someone who has no recollection of a traumatic event, even though they were conscious and aware during the event. In classical psychoanalytic theory the basic defence that excludes painful experiences and unacceptable impulses from consciousness. Repression operates on an unconscious level as a protection against anxiety. It also comes into play in many other forms of defence, as in denial, in which individuals avoid unpleasant realities by first trying to repress them and then negating them when repression fails (APA Dictionary of Psychology, 2020).
Splitting	Failing to reconcile both positive and negative attributes into a whole understanding of a person or situation, resulting in all-or-none thinking. Splitting is commonly associated with borderline personality disorder.

Adapted from: Polnay, A. (2011). Long-Term Psychodynamic Psychotherapy: A Basic Text (2nd edn), Glen Gabbard, American Psychiatric Publishing, 2010. *The Psychiatrist*, 35(1), pp.38–39. doi:10.1192/pb.bp.110.031849.

Appendix 4

ICD-10 Version: 2019

F43.1 Post-traumatic stress disorder

Arises as a delayed or protracted response to a stressful event or situation (of either brief or long duration) of an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone. Predisposing factors, such as personality traits (e.g. compulsive, asthenic) or previous history of neurotic illness, may lower the threshold for the development of the syndrome or aggravate its course, but they are neither necessary nor sufficient to explain its occurrence. Typical features include episodes of repeated reliving of the trauma in intrusive memories ("flashbacks"), dreams or nightmares, occurring against the persisting background of a sense of "numbness" and emotional blunting, detachment from other people, unresponsiveness to surroundings, anhedonia, and avoidance of activities and situations reminiscent of the trauma. There is usually a state of autonomic hyperarousal with hypervigilance, an enhanced startle reaction, and insomnia. Anxiety and depression are commonly associated with the above symptoms and signs, and suicidal ideation is not infrequent. The onset follows the trauma with a latency period that may range from a few weeks to months. The course is fluctuating but recovery can be expected in the majority of cases. In a small proportion of cases the condition may follow a chronic course over many years, with eventual transition to an enduring personality change (F62.0).

Appendix 5

The National Institute for Health and Care Excellence (NICE, 2018) guideline for current therapeutic interventions that have been developed specifically to treat PTSD for adults

Prevention for adults

1.6.15 Offer an individual trauma-focused CBT intervention to adults who have acute stress disorder or clinically important symptoms of PTSD and have been exposed to 1 or more traumatic events within the last month. These interventions include:

- cognitive processing therapy
- cognitive therapy for PTSD
- narrative exposure therapy
- prolonged exposure therapy. [2018]

Treatment for adults

1.6.16 Offer an individual trauma-focused CBT intervention to adults with a diagnosis of PTSD or clinically important symptoms of PTSD who have presented more than 1 month after a traumatic event. These interventions include:

- cognitive processing therapy
- cognitive therapy for PTSD
- narrative exposure therapy
- prolonged exposure therapy. [2018]

1.6.17 Trauma-focused CBT interventions for adults should:

- be based on a validated manual
- typically be provided over 8 to 12 sessions, but more if clinically indicated, for example if they have experienced multiple traumas
- be delivered by trained practitioners with ongoing supervision
- include psychoeducation about reactions to trauma, strategies for managing arousal and flashbacks, and safety planning
- involve elaboration and processing of the trauma memories
- involve processing trauma-related emotions, including shame, guilt, loss and anger

- involve restructuring trauma-related meanings for the individual
- provide help to overcome avoidance
- have a focus on re-establishing adaptive functioning, for example work and social relationships
- prepare them for the end of treatment
- include planning booster sessions if needed, particularly in relation to significant dates (for example trauma anniversaries). [2018]

Appendix 6

Table illustrating the inclusion and exclusion criteria for the literature review.

Inclusion Criteria	Exclusion Criteria
Full-text articles	Abstract only
Peer-reviewed journals	Non-peer-reviewed journals
Written in the English Language	Not written in the English Language
Female population	Not female population
Sexual assault	Nonsexual assault
Adult population over 18 years	Non-adult population over 18 years
Publication date 2010 - present	Publication date before 2010
Research relevant to disengagement from PTSD therapies	Research not relevant to disengagement from PTSD therapies

Appendix 7a

Critical Appraisal Skills Programme (CASP), (2021).

Summary of the quality appraisal of 33 quantitative studies, using the CASP checklist.

Author and year	Title	Focus	Study Design	Sample	Country	Appraisal Summary
Campanini, R. F., Schoedl, A. F., Pupo, M. C., Costa, A. C., Krupnick, J. L., and Mello, M. F. (2010)	'Efficacy of interpersonal therapy-group format adapted to post-traumatic stress disorder: an open-label add-on trial'	Evaluated interpersonal therapy, in a group format, adapted to PTSD (IPT-G PTSD), as an adjunctive treatment for patients who failed to respond to conventional psychopharmacological treatment.	Clinical Trial **Mixed trauma types**	40	US	Thirty-three patients completed the trial. IPT-G PTSD was effective not only in **decreasing symptoms of PTSD**, but also in decreasing symptoms of anxiety and depression. It led to significant improvements in social adjustment and quality of life. It was well tolerated and there were few dropouts. Our results are very preliminary; they need further confirmation through randomized controlled clinical trials.
Van Minnen, A., Hendriks, L. and Olff, M. (2010)	'When do trauma experts choose exposure therapy for PTSD patients? A controlled study of therapist and patient factors'	When and why therapists opt for or rule out imaginal exposure (IE) for patients with PTSD.	RCT – Cases **Mixed trauma types**	255	UK	Trauma experts were randomized to two conditions and presented with four cases in which the patients' comorbidity and treatment preferences were manipulated. The results confirmed IE to be an underutilised approach, with most professionals being undertrained in the technique. Patient factors influenced expert's choice of therapy: in case of a comorbid

						depression, IE was significantly less preferred than medication. IE was significantly more likely to be offered when patients expressed a preference for trauma-focused treatment. Therapist factors were found to be related to treatment preferences, with high credibility in the technique being positively related to the therapists' preference for IE.
Silveira Júnior, E., Polanczyk, G. V., Hauck, S., Eizirik, C. L., Ceitlin, L. H. (2011)	'Can countertransference at the early stage of trauma care predict patient dropout of psychiatric treatment?'	Investigated the association between feelings of countertransference (CT) at the early psychiatric care provided to trauma victims and treatment outcome	Multivariate analysis **Mixed trauma types**	131 (83% women)	Brazil	The median number of appointments was 5, absences 1, and the dropout rate was 34.4%. The discharge group and the dropout group shared similar clinical and demographic characteristics. Patients with a reported history of childhood trauma were 61% less likely to dropout from treatment than patients with no reported history of childhood trauma. There was no association between initial CT and treatment outcome. Further studies should assess changes in CT during treatment, and how such changes impact treatment outcome.
Bryant, R. A., Mastrodomenico, J., Hopwood, S., Kenny, L., Cahill, C., Kandris, E., Taylor, K. (2013)	'Augmenting cognitive behaviour therapy for post-traumatic stress disorder with emotion tolerance training: a	Many patients do not adhere to or benefit from cognitive behaviour therapy (CBT) for post-traumatic stress disorder (PTSD). The study evaluates the extent to which	RCT **Mixed trauma types**	70	UK	Patients randomized to treatment of either supportive counselling followed by CBT (Support/CBT) or emotion regulation training followed by CBT (Skills/CBT).

	randomized controlled trial'	preparing patients with emotion regulation skills prior to CBT enhances treatment outcome.				Skills/CBT resulted in fewer treatment dropouts, **less PTSD** and anxiety, and fewer negative appraisals at 6 months follow-up than Support/CBT. More Skills/CBT patients achieved high end-state functioning at follow-up than patients in Support/CBT. Evidence suggests that response to CBT may be enhanced in PTSD patients by preparing them with emotion regulation skills. High attrition of participants during the study limits conclusions from this study.
Ehlers, A., Grey, N., Wild, J., Stott, R., Liness, S., Deale, A., Handley, R., Albert, I., Cullen, D., Hackmann, A., Manley, J., McManus, F., Brady, F., Salkovskis, P., Clark, D. M. (2013)	'Implementation of cognitive therapy for PTSD in routine clinical care: effectiveness and moderators of outcome in a consecutive sample'	Study investigated whether Cognitive Therapy for PTSD (CT-PTSD) can be effectively implemented into a UK National Health Service Outpatient Clinic serving a defined ethnically mixed urban catchment area.	RCT **Mixed trauma types**	330	UK	Patients with PTSD were treated by 34 therapists, who received training and supervision in CT-PTSD. Pre and post treatment data (PTSD symptoms, anxiety, depression) were collected for all patients, including dropouts. CT-PTSD was well tolerated and led to very large improvement in PTSD symptoms, depression, and anxiety. Most patients showed reliable improvement/clinically significant change. Dropouts and unreliable attenders had worse outcome. Treatment gains were maintained during follow-up. Few of the selection criteria used in some RCTs, demographic, diagnostic and trauma characteristics moderated

						treatment outcome, and only social problems and needing treatment for multiple traumas showed unique moderation effects. There were no random effects of therapist on symptom improvement, but therapists who were inexperienced in CT-PTSD had more dropouts than those with greater experience.
Greenwald, R., McClintock, S. and Bailey, T. (2013)	'A Controlled Comparison of Eye Movement Desensitization & Reprocessing and Progressive Counting'	Comparative study of EMDR and PC to treat single incident PTSD	CT – Pilot **Mixed trauma types**	19	UK	Participants in both conditions experienced significant **reductions in PTSD symptoms**, memory-related distress, and presenting problems at one week posttreatment: maintained at 12-week follow-up, with no significant differences in outcomes, treatment efficiency, or dropout rate. PC is as efficient, well-tolerated, and effective trauma treatment as those recommended EST TFT.
Imel, Z. E., Laska, K., Jakupcak, M., Simpson, T. L. (2013)	'Meta-analysis of dropout in treatments for posttraumatic stress disorder'	Conducted a meta-analysis of dropout among active treatments in clinical trials for PTSD.	Meta-analysis **Mixed trauma types**	42 studies	US	Dropout varies between active interventions for PTSD across studies, but variability is primarily driven by differences between studies. There do not appear to be systematic differences across active interventions when they are directly compared in the same study. The degree of clinical attention placed on the traumatic event does not appear to be a

						primary cause of dropout from active treatments. However, comparisons of PCT may be an exception to this general pattern, trauma-focused treatments resulted in higher dropout compared with present-centered therapy (PCT).
Butollo, W, König, J, Karl, R, Henkel, C., Rosner, R (2014)	'Feasibility and outcome of dialogical exposure therapy for posttraumatic stress disorder: A pilot study with 25 outpatients'	Research on psychotherapy for posttraumatic stress disorder (PTSD) stems predominantly from a cognitive-behavioural orientation while other approaches are underrepresented. Study evaluated dialogical exposure in trauma therapy (DET), a treatment for PTSD combining cognitive-behavioural elements with an interpersonal, gestalt-based framework.	Uncontrolled Pilot study **Mixed trauma types**	25	UK	There was a significant **reduction in self-rated PTSD symptoms** from pre- to posttreatment. Effect sizes were large in the completer sample and moderate to large in the intent-to-treat sample. General psychopathology also decreased significantly. The dropout rate was rather low at 16%. Results show that further research on DET as a treatment for PTSD is warranted.
Jayawickreme, N., Cahill, S.P., Riggs, D.S., Rauch, S.A.M., Resick, P.A., Rothbaum, B.O., Foa, E.B. (2014)	'Primum non nocere (first do no harm): Symptom worsening and improvement in female assault victims after prolonged exposure for ptsd'	This study evaluated pre- to posttreatment symptom worsening for several empirically supported therapies to determine whether PE is harmful compared to WL and compared to other active treatments, specifically SIT, CPT, EMDR, and PE combined with SIT or CR. **Female assault survivors** with chronic PTSD were randomly assigned to treatments to evaluate participants who showed reliable symptom change: worsening and improvement.	RCT	4 studies; 361	US	Most participants completing one of the active treatments showed reliable improvement on both PTSD and depression compared to WL. Reliable PTSD worsening was nonexistent and the rate of reliable worsening of depression was low. There were no differences on any outcome measures among treatments. By comparison, participants in WL had higher rates of reliable symptom worsening for both PTSD and depression. PE and a number of other empirically

						supported therapies are efficacious and safe treatments for PTSD.
Shnaider, P., Vorstenbosch, V., Macdonald, A., Wells, S. Y., Monson, C. M., Resick, P. A. (2014)	'Associations between functioning and PTSD symptom clusters in a dismantling trial of cognitive processing therapy in **female interpersonal violence** survivors'	This study sought to determine if different domains of psychosocial functioning (e.g., daily living, work, nonfamily relationships) improved following trauma-focused treatment for posttraumatic stress disorder (PTSD). Cognitive processing therapy (CPT), with written trauma accounts, was compared to its components: CPT without the written accounts.	RCT (Dismantling study comparing full CPT to its components)	78	US	Overall and individual domains of functioning significantly improved with treatment and results were similar across treatment groups, Additionally, improvements in the emotional numbing and improvements in the hyperarousal symptom were associated with outcomes in the overall, daily living, and household tasks domains.
Wells A, Walton D, Lovell K, Proctor D. (2015)	'Metacognitive Therapy Versus Prolonged Exposure in Adults with Chronic Post-traumatic stress disorder: A Parallel Randomized Controlled Trial'	Compared metacognitive therapy (MCT) with prolonged exposure (PE) in patients with PTSD of ≥3 months duration. Participants were assigned to; eight sessions of therapy (MCT or PE) or an 8-week wait period (WL).	RCT **Mixed trauma types**	32	Germany	Both active treatments were effective, resulting in significantly **lower symptoms of PTSD**, anxiety and depression compared with the WL. At post-treatment MCT was superior to PE on self-report symptoms of PTSD and superior to WL on objective measures of hyper-arousal. Clinical gains remained evident at follow-up by which time the treated groups did not differ. Both treatments were effective, but MCT had a clear advantage.
Gutner, C. A., Gallagher, M. W., Baker, A. S., Sloan, D. M., Resick, P. A. (2016)	'Time course of treatment dropout in cognitive-behavioral therapies for	Examined when during treatment individuals drop out of CBT for PTSD. Women with PTSD from **interpersonal violence** were randomized to 1 of several PTSD	RCT	321	US	Thirty-nine percent of participants dropped out of treatment, and those who dropped out tended to do so by midtreatment. Moreover, the pattern of treatment dropout

	posttraumatic stress disorder'	treatments including prolonged exposure (PE), cognitive processing therapy (CPT), CPT—cognitive only (CPT–C), and written accounts (WA).				was consistent across CBT conditions. Additional research is needed to examine if treatment dropout patterns are consistent across treatment modalities and settings
Kelly, A., and Garland, E. L. (2016)	'Trauma-Informed Mindfulness-Based Stress Reduction for Female Survivors of **Interpersonal Violence**: Results From a Stage I RCT'	Evaluated a novel trauma-informed model of mindfulness-based stress reduction (TI-MBSR) as a phase I trauma intervention for female survivors of interpersonal violence (IPV). Method A community-based sample of women were randomly assigned to an 8-week TI-MBSR intervention (n = 23) or a waitlist control group (n = 22). Symptoms of posttraumatic stress disorder (PTSD) and depression as well as anxious and avoidant attachment were assessed pre- and postintervention.	Pilot RCT	45	US	Relative to the control group, participation in TI-MBSR was associated with statistically and clinically significant decreases in PTSD and depressive symptoms and significant reductions in anxious attachment. Retention in the intervention was high, with most participants completing at least 5 of the 8 sessions for the intervention. Minutes of mindfulness practice per week significantly predicted reductions in PTSD symptoms. TI-MBSR appears to be a promising and feasible phase I intervention for female survivors of interpersonal trauma.
Larsen, S. E., Wiltsey Stirman, S., Smith, B. N., Resick, P. A. (2016)	'Symptom exacerbations in trauma-focused treatments: Associations with treatment outcome and non-completion'	Trauma-focused treatments are underutilized, partially due to clinician concerns of symptom exacerbation or dropout. Examined a sample of women with **interpersonal violence** type PTSD undergoing Prolonged Exposure (PE), Cognitive Processing Therapy (CPT), and a version of CPT (CPT-C) without	RCT (Dismantling study comparing full CPT to its components)	192 drawn from two RCTs	UK	Neither diagnostic nor trauma-related factors at pre-treatment predicted symptom exacerbations. Symptom exacerbations were not related to treatment non-completion.

		a written trauma narrative to investigate the possibility of symptom exacerbation.				
Markowitz, J. C., Neria, Y., Lovell, K., Van Meter, P. E., Petkova, E. (2017)	'History of sexual trauma moderates psychotherapy outcome for posttraumatic stress disorder'	Tested the moderating effects of trauma type for three psychotherapies in 110 unmedicated patients with chronic DSM-IV trauma type interpersonal, sexual, physical PTSD. Patients were randomized to 14 weeks of prolonged exposure (PE, N = 38), interpersonal psychotherapy (IPT, N = 40), or relaxation therapy (RT, N = 32). Thirty-nine (35%) patients reported **sexual**, 68 (62%) physical, and 102 (93%) **interpersonal trauma**.	RCT	110	US	All therapies had similar efficacy among nonsexual-traumatized patients, IPT had greater efficacy among sexually traumatized patients. Few studies have assessed effects of varying trauma types on effects of differing psychotherapies. In this exploratory study, sexual trauma moderated PTSD outcomes of three therapies: IPT showed greater benefit for sexually traumatized patients than PE or RT.
Müller-Engelmann, M., Wünsch, S., Volk, M., Steil, R. (2017)	'Mindfulness-based stress reduction (MBSR) as a standalone intervention for posttraumatic stress disorder after mixed traumatic events: A mixed-methods feasibility study'	This study examined the feasibility of mindfulness-based stress reduction (MBSR) as a standalone intervention in patients with PTSD who have experienced mixed traumatic events. Patients were assessed prior to treatment, post-treatment and at a 1-month follow-up through self-ratings to determine the effects of the intervention. After the intervention, the patients participated in qualitative interviews regarding their experiences with MBSR and their ideas for future improvements.	Mixed methods feasibility study (analyses of quantitative and qualitative data) **Mixed trauma types**	14	Switzerland	Nine patients finished the program, and these patients considered the exercises to be applicable and helpful. Large effects regarding the reduction of PTSD symptoms among completers confirmed the efficacy of MBSR in reducing PTSD symptoms. In the qualitative interviews, the patients reported an augmentation of wellbeing and improvement regarding the handling of difficult situations and more distance from the traumatic event. Despite the large effects, the high dropout rates and the results of the post-treatment

						interviews suggest that the intervention should be better adapted to the needs of PTSD patients, e.g., by giving more information regarding the exercises and by including shorter exercises to manage acute distress.
Szafranski, D. D., Smith, B. N., Gros, D. F., Resick, P. A. (2017)	High rates of PTSD treatment dropout: A possible red herring?	Investigated PTSD and depression symptom change in patients (**female rape victims**) with PTSD who discontinued psychotherapy.	RCT	321	UK	Considerable proportions of participants displayed significant improvement and/or met good end-state criteria for PTSD and depression. Results also revealed that participants who displayed symptom improvement were younger, attended more treatment sessions, were married or partnered, and had higher annual household income. Although preliminary, these findings contradict belief that treatment dropouts do not display symptom improvement.
Hendriks, L, Kleine, RA de, Broekman, TG, Hendriks, G-J and Minnen, A Van (2018)	'Intensive prolonged exposure therapy for chronic PTSD patients following multiple trauma and multiple treatment attempts'	To explore the effectiveness and safety of intensive prolonged exposure (iPE) targeting chronic PTSD patients with a likely diagnosis of ICD-11 Complex PTSD following multiple **interpersonal traumas** and a history of multiple treatment attempts.	Meta-Analysis	73	UK	A baseline-to- posttreatment decrease in PTSD symptom severity persisted during the three- and six-month follow-ups with large effect sizes; 71% of the participants responded. None of the participants dropped out during the intensive phase and only 5% during the booster phase. Adverse events were extremely low and only a minority showed symptom exacerbation.

Keefe, J. R., Wiltsey Stirman, S., Cohen, Z. D., DeRubeis, R. J., Smith, B. N., Resick, P. A. (2018)	'In **rape trauma** PTSD, patient characteristics indicate which trauma-focused treatment they are most likely to complete'	Comparing prolonged exposure (PE) and cognitive processing therapy (CPT) and drop out for rape-induced PTSD.	RCT	160	US	Dropout rates between patients who did and did not receive their model-indicated treatment were compared. Despite equivalent dropout rates across treatments, patients assigned to their model-indicated treatment were significantly less likely to drop out relative to patients who did not dropout. Individual differences among patients affect the likelihood they will complete a particular treatment, and clinicians can consider these moderators in treatment planning.
Van Woudenberg, C, Voorendonk, EM, Bongaerts, H, Zoet, HA, Verhagen, M, Lee, CW, Van Minnen, A., De Jongh, A. (2018)	'Effectiveness of an intensive treatment programme combining prolonged exposure and eye movement desensitization and reprocessing for severe post-traumatic stress disorder'	The aim of this study was to determine the effectiveness of an intensive trauma-focused treatment programme over 8 days for individuals suffering from severe PTSD. All participants had experienced multiple traumas, including sexual abuse.	Meta-Analysis **Mixed trauma types**	347 (70% women)	UK	A significant **decline in symptom severity was** found: 82.9% showed a clinically meaningful response and 54.9% a loss of diagnosis. Dropout was very low (2.3%). Conclusions: Intensive trauma-focused treatment programmes including prolonged exposure, EMDR therapy, and physical activity can be effective for patients suffering from severe PTSD and are associated with low dropout rates.
Zepeda Méndez, M., Nijdam, M.J., ter Heide, F.J.J., Van der Aa, N., Olff, M. (2018)	'A five-day inpatient EMDR treatment programme for PTSD: pilot study'	The aim of the current study was to investigate the feasibility and preliminary effectiveness of an intensive five-day inpatient treatment with Eye Movement Desensitization and Reprocessing	Pilot study **Mixed trauma types**	12	UK	PTSD **symptoms significantly improved.** Nine of the 11 patients who completed treatment showed reliable changes in terms of self-reported PTSD. At three-month follow-up two of the patients no

		(EMDR) and trauma-informed yoga for patients with PTSD.				longer met criteria for PTSD. One patient dropped out after the first day. No serious adverse events occurred.
Belsher, B. E., Beech, E., Evatt, D., Smolenski, D. J., Shea, M. T., Otto, J. L., Rosen, C. S., Schnurr, P. P. (2019)	'Present-centered therapy (PCT) for post-traumatic stress disorder (PTSD) in adults'	To assess the effects of PCT for adults with PTSD. Study sought to determine whether PCT is more effective in alleviating symptoms relative to control conditions; PCT results in similar alleviation of symptoms compared to TF-CBT; if PCT is associated with lower treatment dropout as compared to TF-CBT.	Systematic review Meta-analysis **Mixed trauma types**	12 studies	UK	Moderate-quality evidence indicates that PCT is more effective in **reducing PTSD severity** compared to control conditions. Low quality of evidence did not support PCT as a non-inferior treatment compared to TF-CBT on clinician-rated post-treatment PTSD severity. The treatment effect differences between PCT and TF-CBT may attenuate over time. PCT participants drop out of treatment at lower rates relative to TF-CBT participants.
Holmes, S. C., Johnson, C. M., Suvak, M. K., Sijercic, I., Monson, C. M., and Wiltsey Stirman, S. (2019).	'Examining patterns of dose response for clients who do and do not complete cognitive processing therapy'	The study examined temporal patterns of treatment non-completion and the relationships among non-completion, PTSD, and overall mental health functioning outcomes, among clients in a CPT implementation trial.	RCT **Mixed trauma types**	188	UK	42% of clients did not complete treatment, with most discontinuing between sessions two and five. Data did not fit the dose-effect or good-enough level model. Rather, clients who improved at a greater rate in their PTSD symptoms and overall mental health functioning attended *more* sessions. The average client had the best outcomes when they completed all 12 sessions.
Proença, C. R., Markowitz, J. C., Prado, E. A., Braga,	'Attrition in Interpersonal Psychotherapy Among	Assessed attrition rates in IPT of sexually assaulted women recently diagnosed with PTSD	RCT	32	Switzerland	Overall attrition was 29%. One patient was withdrawn because of suicidal risk; four dropped out

R., Coimbra, B. M., Mello, T. F., Maciel, M. R., Pupo, M., Póvoa, J., Mello, A. F., and Mello, M. F. (2019)	Women with Post-traumatic Stress Disorder Following **Sexual Assault'**	Interpersonal Psychotherapy (IPT), adapted to treat PTSD (IPT-PTSD) was implemented to examine similar efficacy to and lower dropout rates than Prolonged Exposure (PE), the "gold standard," most studied exposure therapy for PTSD.				pre-treatment, and five dropped out during IPT-PTSD. If the excluded patient is considered a dropout, the rate increases to 31%. This is the first formal study of IPT for PTSD specifically due to sexual assault. IPT attrition approximated dropout rates in PE studies, which are often around 30%.
Youn, S. J., Mackintosh, M. A., Wiltsey Stirman, S., Patrick, K. A., Aguilar Silvan, Y., Bartuska, A D., Shtasel, D. L., Marques, L. (2019)	'Client-level predictors of treatment engagement, outcome, and dropout: Moving beyond demographics'	Study explored client-level predictors of treatment outcome and dropout beyond client demographics, and to identify client-level predictors of treatment engagement in community settings.	Secondary data analysis **Mixed trauma types**	52	UK	Results showed language as a significant predictor of treatment engagement. There were significant differences between Spanish and English-speaking clients, with the former tending to repeat more session content than the latter and less likely to attend treatment frequently and consistently. Irrespective of language, clients who reported high quality of life at baseline were less likely to repeat CPT session content and those with increased baseline barriers to treatment had deceleration in PTSD symptom improvement over time. In terms of treatment engagement moderators impacting treatment outcome, clients who repeated more session content were more likely to complete treatment.

Alpert, E., Hayes, A. M., Barnes, J. B., Sloan, D. M. (2020)	Predictors of Dropout in Cognitive Processing Therapy for PTSD: An Examination of Trauma Narrative Content	Examined predictors of dropout in cognitive processing therapy (CPT) by coding the content of trauma narratives written in early sessions of CPT.	RCT **Mixed trauma types**	51	UK	CPT showed significantly higher dropout rates than written exposure therapy group. Sixteen in this subsample were classified as dropouts and 35 as completers. An additional 9 participants dropped out but could not be included because they did not complete any narratives. Of the 11 participants who provided a reason for dropout, 82% reported that CPT was too distressing.
Kline AC, Baier AL, Klein AB, Feeny NC, Zoellner LA. (2020	'Differentiating "types" of treatment dropout: Nonstarters in an RCT of prolonged exposure versus sertraline'	This study examined patient dropout prior to treatment and compared these "nonstarters" with treatment starters and in-treatment dropouts. Patients with chronic PTSD were randomized to "choice" (prolonged exposure [PE] or sertraline) or "no choice" (re-randomized to PE or sertraline) and received up to 10 weeks of treatment.	RCT **Mixed trauma types**	200 (70% women)	UK	Relative to patients who began treatment, nonstarters reported less severe PTSD symptomatology and were less likely to have received their preferred treatment. These differences remained even when comparing nonstarters to patients that began treatment but eventually dropped out. Differences in beliefs (i.e., perceived credibility) toward one treatment versus the other were also linked to pretreatment dropout. A significant portion of dropout occurred prior to treatment. PTSD severity and receiving preferred treatment were tied to pretreatment dropout. Treatment beliefs were linked to pretreatment dropout. Dropouts prior to treatment differed from in-treatment dropouts. Dropout

						risk factors may differ across stages of treatment.
Lewis, C., Roberts, N. P., Gibson, S., Bisson, J. I. (2020)	'Dropout from psychological therapies for post-traumatic stress disorder (PTSD) in adults: systematic review and meta-analysis'	To ascertain rates of dropout across different modalities of psychological therapy for PTSD and to explore potential sources of heterogeneity.	RCT Meta-analysis **Mixed trauma types**	7724 drawn from 115 RCTs	UK	Found evidence that psychological therapies with a trauma-focus were significantly associated with greater dropout. The pooled rate of dropout from RCTs of psychological therapies for PTSD was 16%. Dropout rates from recommended psychological therapies for PTSD are high and this appears to be particularly true of interventions with a trauma focus.
Booysen, D. D. and Kagee, A. (2021)	'Preliminary Effectiveness of Brief Prolonged Exposure Therapy for PTSD: Expanding Access to Effective Therapies'	The preliminary effectiveness of a brief prolonged exposure therapy (PE) for PTSD in South Africa, a low resource setting. All female case study, 4 of 7 women had experienced **sexual-assault** type PTSD.	Clinical Case Studies	7	US	Overall, brief PE reduced symptoms of PTSD, depression, and anxiety from baseline to post-intervention, and at 3-month follow-up. A downward trend in symptoms was evident during treatment, with slight symptom variations during exposure sessions. In conclusion, a six-session brief PE intervention produced positive outcomes for PTSD, depression, and anxiety at two community counselling centres in South Africa.
Haven, S. E., Brown, W. J., Berfield, J. B., and Bruce, S. E. (2021)	'Predictors of Attrition and Response in Cognitive Processing Therapy for **Interpersonal Trauma** Survivors with PTSD'	Investigated factors potentially related to premature termination and treatment response in Cognitive Processing Therapy with written account (CPT-A).	Regression analysis	42	US	Age was a significant factor related to dropout from CPT-A whereas PTSD symptom severity was significantly related to treatment response. Results inform the application of CPT-A

						for PTSD in survivors of interpersonal trauma, as identified predictors of dropout and non-response at intake may contribute to treatment retention and response.
Shnaider, P., Boyd, J. E., Cameron, D. H., McCabe, R. E. (2021)	'The relationship between emotion regulation difficulties and PTSD outcomes during group cognitive processing therapy for PTSD'	The study sought to determine the impact of pre-treatment emotion regulation difficulties on PTSD treatment outcomes and dropout, as well as whether emotion regulation difficulties improve over the course of treatment with group CPT among individuals with PTSD. **25% of the sample group experienced sexual assault-type PTSD.**	Regression analysis **Mixed trauma types**	101	US	Individuals with PTSD participated in group CPT. Results revealed that pre-treatment emotion regulation difficulties were neither significantly associated with changes in PTSD symptoms over the course of treatment nor with treatment dropout. These findings suggest that CPT delivered in a group setting to individuals with PTSD can lead to significant improvement in emotion regulation and that emotion regulation difficulties do not negatively impact treatment outcome or patient retention.
Sijercic, I., Liebman, R. E., Stirman, S. W., Monson, C. M. (2021)	'The Effect of Therapeutic Alliance on Dropout in Cognitive Processing Therapy for Posttraumatic Stress Disorder'	Examined the association between therapeutic alliance and treatment dropout among participants in CPT for PTSD before receiving a full course of treatment.	Randomized implementation effectiveness trial **Mixed trauma types**	169	US	In total, 33.1% of clients dropped out over the course of CPT, and nearly half of these individuals dropped out during the first six sessions. Results indicated mean ratings of alliance significantly predicted treatment dropout, whereas initial alliance, late alliance, and change in alliance over treatment did not. These findings suggest that overall therapeutic alliance is an

						important predictor of dropout from CPT.
Storm M.P., Christensen K.S. (2021)	'Comparing treatments for post-traumatic stress disorder – a systematic review'	Aim of the study was to compare the outcomes of treatment by psychotherapy and medications. An additional aim was to explore the combinations of treatment modalities in adults with PTSD and to investigate differences in drop-out rates.	Systematic review and Meta-Analysis of RCTs **Mixed trauma types**	7 studies	Danish	Three studies showed that psychotherapy was superior to selective serotonin reuptake inhibitors. Two studies showed an augmenting effect with prolonged exposure. Two studies showed no differences across the treatment groups. In four of the included studies, patients treated with psychotherapy were more likely to drop out. Both medication and psychotherapy have an effect on PTSD, but psychotherapy tends to provide greater and more long-lasting outcome improvements. Trauma type, PTSD severity and other variables affect drop-out rates and treatment outcomes.

Appendix 7b

Critical Appraisal Skills Programme (CASP), (2021).

Summary of the quality appraisal of 2 qualitative studies, using the CASP checklist.

Author and year	Title	Focus	Study Design	Sample	Country	Appraisal Summary
Frye, L. A. and Spates, C. R. (2012)	'Prolonged Exposure, Mindfulness, and Emotion Regulation for the Treatment of PTSD'	Concerns of PET for PTSD regarding clinical applications including exacerbation of symptoms during exposure, poor adherence to treatment, and early treatment dropout are suggested to occur because of an unwillingness for some PTSD clients to confront feared trauma-relevant stimuli and experience anxious arousal during exposure. Mindfulness and Emotion Regulation skills during PET may be a useful substitute for clients' attempts to escape, avoid, or control anxious arousal during treatment for **sexual-assault** type PTSD.	Case Study	1	US	The article discusses the client's success with the mindfulness, emotion regulation, and PET approach, in addition to reductions in anxiety sensitivity over the course of treatment. At the end of treatment, the client no longer met the criteria for PTSD, which was maintained at three months follow-up.
Paintain, E. and Cassidy, S. (2018)	'First-line therapy for post-traumatic stress disorder: A systematic review of cognitive behavioural therapy and psychodynamic approaches'	Existing research exploring effective therapeutic interventions for PTSD includes trauma-focused CBT involving exposure techniques. The present review sought to establish the treatment efficacy of CBT and PDT approaches and considers the potential impact of selecting PDT-based techniques over CBT-based techniques for the treatment of PTSD.	Systematic review of studies using CBT and PDT. **Mixed trauma types**	12	UK	The evidence reviewed provided examples supporting PDT-based therapy as an effective treatment for PTSD but confirmed CBT as more effective in the treatment of this disorder. Comparable dropout rates were reported for both treatment approaches, suggesting that relative dropout rate should not be a factor in the selection of a PDT approach over CBT for treatment of PTSD.

Appendix 8

CHECKLIST **Part 1**

A checklist should be completed for every research project in order to identify whether a full application for ethics approval needs to be submitted.

The principal investigator or, where the principal investigator is a student, the supervisor/module leader is responsible for exercising appropriate professional judgement in this review.

This checklist must be completed before potential participants are approached to take part in any research. (All boxes are expandable)

Section I: Project details				
Project title:	What influences women with sexual assault PTSD to disengage from therapy early?			
Describe the aims of your research and how you are going to manage ethical issues or concerns (in no more than 500 words) Please see accompanying paper.				
Planned start date: January 2015		Planned end date: July 2016		
Funder:				
Section II: Applicant details				
Applicant name:	Tracy Evans			
Department:	Centre for Professional Practice, Research and Development Centre			
Email: tme6@kent.ac.uk		Telephone number: 07904337895		
Contact address:	11 Flat B Haydon Park Road, Wimbledon London SW19 8JQ			
Applicant signature:				
Section III: Students only				
Undergrad. ☐	Postgrad ☐	Masters ☐	Doctorate ✓☐	Other (please specify)
Supervisor / Module Convenor's name:	Dr N Riding			
Supervisor / Module Convenor's signature:				

Please note that it is your responsibility to follow, and to ensure that all researchers involved with your project follow, accepted ethical practice and appropriate professional ethical guidelines in the conduct of your study. You must take all reasonable steps to protect the dignity, rights, safety and well-being of participants. This includes providing participants with appropriate information sheets, ensuring informed consent and ensuring confidentiality in the storage and use of data.

If all questions in the checklist are answered as 'No', **please send the completed and signed form to The Secretary, Centre for Professional Practice Research Ethics and Governance Committee. Email: cppethics@kent.ac.uk with any further required documents, for their records.**

*If any questions in Section IV(A) are answered 'Yes', y***ou will need to consult Nicole Palmer (N.R.Palmer@kent.ac.uk), the Research Ethics and Governance Officer in Research Services. Any required forms should be completed with her guidance. You will then need to send a copy of the completed form to the Centre for Professional Practice.**

If any questions in Section IV(B) are answered 'yes', **you will need to complete the full application form and send it to the Centre for Professional Practice Research Ethics and Governance Committee for review, along with a copy of the project protocol and any supporting documentation such as patient information sheets and consent forms.**

Any significant change in the question, design or conduct over the course of the research should be notified to the Centre for Professional Practice Research Ethics and Governance Committee and may require a new application for ethics approval.

Part 1 (Cont'd)

Section IV: Research Checklist

Please answer all questions by ticking the appropriate box:

A) **Research that may need to be reviewed by an NHS Research Ethics Committee, the Social Care Research Ethics Committee (SCREC) or other external ethics committee (if *yes*, please give brief details as an annex)**	**YES**	**NO**
Will the study involve recruitment of patients through the NHS or the use of NHS patient data?	☐	✓☐
Will the study involve the collection of tissue samples (including blood, saliva, urine, etc.) from participants or the use of existing samples?	☐	✓☐
Will the study involve participants, or their data, from adult social care, including home care, or residents from a residential or nursing care home?	☐	✓☐
Will the study involve research participants identified because of their status as relatives or carers of past or present users of these services?	☐	✓☐
Does the study involve participants aged 16 or over who are unable to give informed consent? (e.g. people with learning disabilities or dementia)	☐	✓☐
Is the research a social care study funded by the Department of Health?	☐	✓☐
Is the research a health-related study involving prisoners?	☐	✓☐

If the answer to any questions in Section IV A is 'yes', please contact the Research Ethics & Governance Officer for further advice and assistance.

B) **Research that may need full review by the Centre for Professional Practice Research Ethics and Governance Committee**	**YES**	**NO**
Does the research involve other vulnerable groups: children; those with cognitive impairment; or those in unequal relationships, e.g. your own students?	☐	✓☐
Will the study require the cooperation of a gatekeeper for initial access to the groups or individuals to be recruited? (e.g. students at school; members of a self-help group?)	☐	✓☐
Will it be necessary for participants to take part in the study without their knowledge and consent at the time? (e.g. covert observation of people in non-public places?)	☐	✓☐
Will the study involve discussion of sensitive topics (e.g. sexual activity; drug use; criminal activity?)	☐	✓☐
Are drugs, placebos or other substances (e.g. food substances, vitamins) to be administered to the study participants or will the study involve invasive, intrusive or potentially harmful procedures of any kind?	☐	✓☐
Is pain or more than mild discomfort likely to result from the study?	☐	✓☐
Could the study induce psychological stress or anxiety or cause harm or negative consequences beyond the risks encountered in normal life?	✓☐	☐
Will the study involve prolonged or repetitive testing?	☐	✓☐
Will the research involve administrative or secure data that requires permission from the appropriate authorities before use?	☐	✓☐
Is there a possibility that the safety of the researcher may be in question (e.g. international research; locally employed research assistants)?	☐	✓☐
Does the research involve members of the public in a research capacity (participant research)?	☐	✓☐
Will the research take place outside the UK?	☐	✓☐

Will the research involve respondents to the internet or other visual/vocal methods where respondents may be identified?	☐	✓☐
Will research involve the sharing of data or confidential information beyond the initial consent given?	☐	✓☐
Will financial inducements (other than reasonable expenses and compensation for time) be offered to participants?	☐	✓☐
Will the proposed findings be controversial or are there any conflicts of interest?	☐	✓☐

FULL APPLICATION

Part 2

If any of the questions in Section IV B is answered 'yes', a full ethics application must be made to the Centre for Professional Practice Research Ethics and Governance Committee. This also applies for studies not defined as 'research' in the narrow sense, i.e. evaluations/audits, etc. Complete this form and send it to the Centre for Professional Practice Research Ethics and Governance Committee along with supporting documentation: a copy of the full research proposal; any participant information sheets and consent forms; any questionnaires, interview schedules; any advertising material or proposed website wording.

Overview

Lay summary. (Please provide a brief summary of the study)

This project will look at service users (SUs) who do not complete the full course of counselling offered in a mental health charity organisation for women. The sexual violence service provides short-term counselling support for women who are victims of rape and sexual violence.

Summary of main issues. (Please summarise the main ethical and design issues arising from the study and explain how you have addressed them)

- Vulnerable group
- Difficult to engage subset
- Risk of re-traumatisation
- The need to provide support (provision made by WS to re-engage vulnerable SUs participating in project)

Please see attached research proposal for comprehensive summary of main issues and how addressed.

What is the principal research question/objective?

An investigation to explore those factors that contribute to SUs with PTSD remaining engaged in short-term counselling

What are the secondary research questions/objectives, if applicable?

The aim of this research is to improve the experience and wellbeing of the SU at WS, and for the outcomes to contribute to the overall improvement in retention for the organisation. There is overriding sense in current research that the difficulty lay with the SU, and not for example the organisation; the counselling model; the therapeutic alliance; the nature of clinical counselling of trauma. The SUs voice is inaudible in most research, and this will be addressed.

How has the scientific/intellectual quality of the research been assessed?

✓☐ Internal review	Details: Doctoral meetings and workshops with other students; progress reviews with academics
☐ Independent external review	
☐ None	

If none, please provide a scientific/intellectual justification for the study.

How have the statistical aspects of the research been reviewed (if relevant)?

✓☐ Internal review	Details: Progress reviews with academics.
☐ Independent external review	
☐ None	

If none, please provide a justification for the sample size (if relevant)
Please describe the methods of analysis (statistical or other appropriate methods, e.g. for qualitative research) by which the data will be evaluated to meet the study objectives
This is a qualitative research project, involving developing a semi-structured interview to conduct with a possible 6 SUs (65% of SUs did not remain in counselling for 16 sessions offered), using IPA coding analysis to evaluate factors for why counselling was interrupted, and for analysis of similarities and correlation between participants etc. Coding verification and accuracy of the interpretation of SU interviews will be validated through other doctorate students, my supervisor or the research group.
Please give a full summary of your design and methodology (it should be clear exactly what will happen to the research participant, how many times and in what order)
The participants will be asked to consent to being involved in the project; to consent for me to access information from their assessments, and agree to possibly being interviewed, which will take approx one hour and be recorded.

Part 2

(Cont'd)

Risks and ethical issues
Please list the principal inclusion and exclusion criteria
Vulnerable SUs (assessed by conducting short screening questions prior to the interview); English is not the SUs first language; SUs who have needed interpreters; SU's who did not return for counselling after completing only the assessment.
How long will each research participant be in the study in total, from when they give informed consent until their last contact with the research team?
From January 2015 to August 2015 on completion of SSI.
What are the potential risks and burdens for research participants and how will you minimise them? (Describe any risks and burdens that could occur as a result of participation in the research, such as pain, discomfort, distress, intrusion, inconvenience or changes to lifestyle. Describe what steps would be taken to minimise risks and burdens as far as possible)
Potential risk is around the interview, and any re-traumatising of the SU. To reduce the risk of distress or anxiety I will develop and conduct a small sheet of 3-5 questions, prior to the interview, to assess whether the SUs can move to the next stage of the full interview. If, at that stage, the questions have highlighted potential risk the SU will complete there, and be given the choice of re-referral to NLRC or signposted to another support service within the NLRC support links.
Please describe what measures you have in place in the event of any unexpected outcomes or adverse effects to participants arising from involvement in the project
The SUs will be referred back to the WS as agreed; and counselling or other appropriate support arranged with a different counsellor. WS has many and various links with the following for signposting, should the SU need particular support, and choose not to re-engage: • Haven/Sexual Assault Referral Centre • Sexual Health • GP • Mental Health service (including Crisis teams and Drayton park) • Complex care service • Maytree • Samaritans • NAPAC • Survivors Trust • National SV help • Other counselling support • Victim Support

• Drug/alcohol support • Housing • Legal advice • Rights of Women • Police • Poppy Project • Migrant support organisation • DV service
Will interviews/questionnaires or group discussions include topics that might be sensitive, embarrassing or upsetting, or is it possible that criminal or other disclosures requiring action could occur during the study?
Yes, there is a possibility of both sensitive and / or upsetting topics occurring. It is unlikely that disclosures of criminal or other action could occur, since this will have already been disclosed at assessment.
If yes, please describe the procedures in place to deal with these issues
In order to reduce distress and / or embarrassment I will conduct a small screening sheet of 3-5 questions to assess whether SUs can move to the next stage of the full interview. If, at the screening stage, I assess the SU is vulnerable, distressed and anxious the SU will complete at that stage, withdrawn from the project and given the choice of re-referral to NLRC or signposted to another support service within the NLRC support links.
What is the potential benefit to research participants?
The potential benefit to participants is a second chance to re-engage with NLRC or with another support service with NLRC links.
What are the potential risks to the researchers themselves?
None
Will there be any risks to the University? (Consider issues such as reputational risk; research that may give rise to contentious or controversial findings; could the funder be considered controversial or have the potential to cause reputational risk to the University?)
None
Will any intervention or procedure, which would normally be considered a party of routine care, be withheld from the research participants? (If yes, give details and justification). For example, the disturbance of a school child's day or access to their normal educational entitlement and curriculum).
No

Part 2

(Cont'd)

Recruitment and informed consent
How and by whom will potential participants, records or samples be identified?
NLRC Database.
Will this involve reviewing or screening identifiable personal information of potential participants or any other person? (If 'yes', give details)
Yes, 1) to check for those participants who have ended their counselling before 16 sessions and 2) to look at information on participants assessments.
Has prior consent been obtained or will it be obtained for access to identifiable personal information?
Yes, consent will be obtained from participants to be involved in the project, to see their assessments, and to be interviewed.
Will you obtain informed consent from or on behalf of research participants? (If 'yes' please give details. If you are not planning to gain consent, please explain why not).
Yes, consent from participants is necessary for me to look at individual assessments, and to see start and end dates of counselling.
Will you record informed consent in writing? (If 'no', how will it be recorded?)
Yes, consent will be recorded in writing.
How long will you allow potential participants to decide whether or not to take part?

Consent to be involved in the research project will be obtained at assessment. Follow-up telephone contact to arrange to meet to carry out the small screening questions and the interview (if appropriate) after the participant has ended counselling support. Participants will still be able to decide not to take part in the research at the follow-up telephone contact.
What arrangements have been made for persons who might not adequately understand verbal explanations or written information given in English, or have special communication needs? (e.g. translation, use of interpreters?)
The exclusion criteria includes: English is not the SUs first language; SUs who have needed interpreters; SU's who did not return for counselling after completing only the assessment.
If no arrangements will be made, explain reasons (e.g. resource constraints)

Part 2
(Cont'd)

Confidentiality
In this section personal data means any data relating to a participant who could potentially be identified. It includes pseudonymised data capable of being linked to a participant through a unique code number.
If you will be undertaking any of the following activities at any stage (including in the identification of potential participants) please give details and explain the safeguarding measures you will employ • Electronic transfer by magnetic or optical media, email or computer networks • Sharing of personal data outside the EEA • Use of personal addresses, postcodes, faxes, emails or telephone numbers • Publication of direct quotations from respondents • Publication of data that might allow identification of individuals • Use of audio/visual recording devices • Storage of personal data on any of the following: – Manual files – University computers – Home or other personal computers – Private company computers – Laptop computers
Participants will not be identified but coding and reference number will be used throughout. Only a home computer will be used, which is not shared by anyone except the researcher.
How will you ensure the confidentiality of personal data? (e.g. anonymisation or pseudonymisation of data)
No identification of individuals will be used, only coding and referencing. Permission to use any direct quotations from respondents will be outlined to those respondents in order that they are comfortable that they are not identified by those quotations.
Who will have access to participants' personal data during the study?
Members of staff working at SWA.
How long will personal data be stored or accessed after the study has ended? (If longer than 12 months, please justify)
Until the end of the doctorate.
Please note: as best practice, and as a requirement of many funders, where practical, researchers must develop a data management and sharing plan to enable the data to be made available for re-use, e.g. for secondary research, and so sufficient metadata must be conserved to enable this while maintaining confidentiality commitments and the security of data.

Part 2
(Cont'd)

Incentives and payments

Will research participants receive any payments, reimbursement of expenses or any other benefits or incentives for taking part in this research? (If 'yes', please give details)
No
Will individual researchers receive any personal payment over and above normal salary, or any other benefits or incentives, for taking part in this research? (If 'yes', please give details)
No
Does the Chief Investigator or any other investigator/collaborator have any direct personal involvement (e.g. financial, shareholding, personal relationship, etc.) in the organisations sponsoring or funding the research that may give rise to a possible conflict of interest? (If 'yes', please give details)
No

Publication and dissemination
How do you intend to report and disseminate the results of the study? If you do not plan to report or disseminate the results please give your justification.
The results of this study will be written up and submitted to appropriate journals for publication.
Will you inform participants of the results? (Please give details of how you will inform participants or justify if not doing so)
Participants can obtain results if they chose to, by contacting me. Details are outlined on the participants information sheet.

Management of the research		
Other key investigators/collaborators. (Please include all grant co-applicants, protocol authors and other key members of the Chief Investigator's team, including non-doctoral student researchers)		
None		
Has this or a similar application been previously rejected by a research Ethics Committee in the UK or another country? (If yes, please give details of rejected application and explain in the summary of main issues how the reasons for the unfavourable opinion have been addressed in this application)		
No		
How long do you expect the study to last?		
• **Planned start date: January 2015**	• **Planned end date: July 2016**	• **Total duration: 18 – 19 months**
Where will the research take place?		
Interviews will be held at a secure location for the participant. Data obtained from home, write-up from home.		

Part 2
(Cont'd)

Insurance/indemnity
Does UoK's insurer need to be notified about your project before insurance cover can be provided? *The majority of research carried out at UoK is covered automatically by existing policies, however, if your project entails more than usual risk or involves an overseas country in the developing world or where there is or has recently been conflict, please check with the Insurance Office that cover can be provided. Please give details below.*

Children
Do you plan to include any participants who are children under 16? (If no, go to next section)
No
Please specify the potential age range of children under 16 who will be included and give reasons for carrying out the research with this age group

Please describe the arrangements for seeking informed consent from a person with parental responsibility and/or from children able to give consent for themselves
If you intend to provide children under 16 with information about the research and seek their consent or agreement, please outline how this process will vary according to their age and level of understanding

Participants unable to consent for themselves	
Do you plan to include any participants who are adults unable to consent for themselves through physical or mental incapacity? (If yes, the research must be reviewed by an NHS REC or SCREC)	
No	
Is the research related to the 'impairing condition' that causes the lack of capacity, or to the treatment of those with that condition?	
☐ Yes	If 'yes' proceed to next question
✓☐ No	If 'no' the study should proceed without involving those who do not have the capacity to consent to participation
Could the research be undertaken as effectively with people who do have the capacity to consent to participate?	
☐ Yes	If 'yes' then the study should exclude those without the capacity to consent to participation
✓☐ No	If 'no' then the inclusion of people without capacity in the study can be justified
Is it possible that the capacity of participants could fluctuate during the research? (If yes, the research must be reviewed by an NHS REC or SCREC)	
No	
Who inside or outside the research team will decide whether or not the participants have the capacity to give consent? What training/experience will they have to enable them to reach this decision?	
The researcher is a counsellor, and has both the training and experience to recognise participants capacity to give consent.	
What will be the criteria for withdrawal of participants?	
If, at the screening stage, I assess the SU to be vulnerable, distressed and anxious, the SU will complete at that stage, and be given the choice of re-referral to NLRC or signposted to another support service within the NLRC support links.	

Part 2

(Cont'd)

Declaration	
To be signed by the Chief Investigator • I agree to comply, and will ensure that all researchers involved with the study comply with all relevant legislation, accepted ethical practice, University of Kent policies and appropriate professional ethical guidelines during the conduct of this research project • If any significant changes are made to the design of the research I will notify the Centre for Professional Practice Research Ethics and Governance Committee and understand that further review may be required before I can proceed to implement the change(s) • I agree that I will notify the Centre for Professional Practice Research Ethics and Governance Committee of any unexpected adverse events that may occur during my research • I agree to notify the Centre for Professional Practice Research Ethics and Governance Committee of any complaints I receive in connection with this research project	
Signed:	Date:

What to do next
Send your completed form, along with all supporting documentation, to The Secretary, Centre for Professional Practice Research Ethics and Governance Committee. Email: cppethics@kent.ac.uk

Checklist	
Please ensure you have included the following with your application:	
• Participant information sheet	X☐
• Consent form	X☐
• Covering letter (if relevant)	X☐
• Any questionnaires/interview schedules/topic guides to be used	X☐
• Any approved instruments/measures to be used	☐
• Any advertising material to be used to recruit participants	☐
• Confirmation that project is covered by UoK insurance policies (if necessary)	X☐
• You have permission from your organization to proceed	X☐
• You have gatekeeper approval for use of data bases (if necessary)	X☐

Appendix 9

Notice included in assessment packs for clinicians to pass to clients.

> *A research project is being conducted at [ ] this year, which is interested in finding out about the number of counselling sessions attended by service users. The researcher might contact you after you have finished treatment, to ask if you would like to be involved in the project.*

Appendix 10

Dear XXXX

I am a counsellor and I work at [ ]. I am writing a project about women who have experienced trauma who do not take up all the counselling sessions offered. I wondered if you would be interested in becoming involved in the project. Involvement is one interview at a time that suits you, which is anonymised and confidential (you will not be recognised).

Women who choose not to have all their counselling sessions do not often have a voice in research, and often go unheard. I would like to redress that.

I hope to hear from you soon, you can reply to this email or call me on [ ].

Many thanks

Appendix 11

Dear XXXX

I wrote to you recently about a project that I am working on for women who do not take up all of the counselling sessions offered at [ ]. I wonder if you have had a chance to think about becoming involved in the project. It is a one-hour interview at [ ], at a time that is convenient for you.

I look forward to hearing from you.

All good wishes

Appendix 12

Screening questions for SSI

1. Are you currently receiving any therapy from other support services?

2. Are you currently in support services with mental health or crisis service?

3. Have you had to visit A&E since leaving therapy support at the charity?

4. Any medication reduced/increased/newly prescribed since leaving therapy at the charity?

Appendix 13

Table illustrating participant inclusion and exclusion criteria for the study

Inclusion Criteria	Exclusion Criteria
English speakers	Non-English speakers
Type 1*	Type 0, Type 2*
Did not complete 16 standard therapy sessions	Completed 16 standard therapy sessions
Attended the assessment and a minimum of one therapy session before disengaging	Only completed the assessment
	Those already seen by the researcher for therapy at the WS
	Assessed at screening as not suitable

*Terr Trauma Categories (Terr, 2013):
Type 0 = No current traumatic stress
Type 1 = Single traumatic event causing stresses; and
Type 2 = Variable, multiple and long-standing trauma events

Appendix 14

Participant Characteristics

Participant P1 – Mira

Mira was 27 years old at the time of the interview for the research project. Mira began 16 weeks of one-to-one therapy at the WS on 12 June 2015, which she stopped attending on 11 September 2015. Mira cancelled two therapy sessions when her counsellor requested to change to a different venue for those sessions. Mira initially agreed and then later cancelled, informing the counsellor after this break that she would not be returning for further sessions. In total, Mira attended 9 of 16 therapy sessions. Mira volunteered to take part in the research project and was interviewed on the 21 January 2016; approximately five months after ending her therapy.

Participant P2 – Hailey

Hailey was 28 years old at the time of the interview for the research project. Hailey began 16 weeks of one-to-one therapy at the WS on 27 August 2015. During the first session Hailey explained to her counsellor that she was sometimes required to travel for work, and that she might have to cancel three therapy sessions: she would confirm with her counsellor prior to the second session. The counsellor reminded Hailey of the therapy contract[54]. Hailey emailed her counsellor informing her that she would need to travel for work and was unable to attend three therapy sessions. Her counsellor informed Hailey that her therapy would have to end, and that she would be returned to the waiting list for the next available therapy slot. Approximately 4.5 months later, Hailey received a telephone call from the WS offering her a second therapy slot. Hailey declined and requested that her name be removed from the waiting list explaining that she had begun private therapy shortly after her therapy was ended at the WS. Hailey volunteered to take part in the research project and was interviewed on the 19 February 2016; approximately six months after therapy was ended.

[54] If two consecutive therapy sessions are missed by the client, the WS reserve the right to bring the sessions to an end due to a long waiting list.

Participant P3 – Alisa

Alisa was 25 years old at the time of the interview for the research project. Alisa began 16 weeks of one-to-one therapy at the WS on 3 March 2016 and ended her therapy sessions on 8 September 2016. During therapy Alisa was offered the maximum 10-week therapy extension by her counsellor, which Alisa initially accepted, making a total of 26 therapy sessions. During her therapy, Alisa cancelled five therapy sessions, and her counsellor also cancelled five therapy sessions[55]. Alisa ended her therapy sessions at session number 22. Alisa attended 17 of 26 planned sessions. Alisa volunteered to take part in the research project and was interviewed on the 6 December 2016; approximately four months after ending therapy.

Participant P4 – Helen

Helen was 29 years old at the time of the interview for the research project. Helen was working in a women's mental health support service when she began therapy at the WS. She began 16 weeks of one-to-one therapy at the WS on 9 September 2016 and ended her therapy sessions on 11 November 2016. During her therapy Helen cancelled three therapy sessions. Helen attended 7 of 16 sessions. Helen volunteered to take part in the research project and was interviewed on the 31 March 2017: approximately five months after ending therapy.

[55] Any therapy sessions cancelled by the counsellor are returned to the client.

Appendix 15

Interview schedule

1) How did you find the charity?
2) How long were you on the waiting list for after completing the assessment? What was it like waiting for [however long]?
3) What did you think therapy would be like? What did you expect if anything?
4) How did you feel when a counsellor contacted you to begin therapy?
5) What was it like meeting your counsellor for the first time?
6) Was there a particular issue that was being addressed in therapy that you were finding difficult
7) At session [session number] did you feel that was enough therapy for you?
8) What did it feel like when you decided that you would not return to therapy?
9) Did you feel any benefit from the therapy sessions that you did attend?
10) Would you re-refer in the future if you felt that you needed that particular support?

Appendix 16

Participant Information Sheet

What influences women with sexual assault PTSD to disengage from therapy?

You are being asked to take part in a research study. Before you decide whether you are willing to take part it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully.

Why is this study being done?
The purpose of this research is to gain insight into why some women attend all counselling sessions offered, and why some women end their counselling earlier than planned.

Why have I been chosen to participate?
I am asking you to take part in this study because you have ended your counselling earlier than planned.

What will happen in this study?
If you decide to take part in this study, you will not need to do anything. I will need your permission to use the information from your assessment. I will also require your permission to interview you once you have completed your counselling, and when you have left the counselling service.

Do I have to take part in the study?
No. It is up to you to decide whether to take part. If you do decide to take part, you will be free to withdraw at any time without giving a reason. The researcher will remove your data from the study, and it will be deleted.

Will my taking part in this study be kept confidential?
Yes. All the information about your participation in this study will be kept confidential. The information that your assessment will provide will be stored on a computer. Only the principal researcher and supervisor will have access to your details, but you will not be recognised by your name but by an allocated reference number. The researcher will not be able to access your email address or internet service provider information. The procedures for handling, processing, storage, and destruction of your data are compliant with the Data Protection Act 1998.

If I take part in this study, how will you protect my privacy?
If you agree to be part of this study you will be giving the researcher your permission to obtain, use and share information about you for this study. The results of this study may be published but this would not include any information that would let others know who you are.

What are the risks from being in this study?
There is no intervention involved in this study. However, you may feel upset, anxious, or stressed about returning to difficult and challenging experiences in your life. Measures to

ensure you are supported are: re-referral to WS counselling and with a different counsellor or referred to a different organisation for support.

What are the possible benefits from being in this study?
You will have the opportunity to re-engage with support services for counselling support should you chose to.

What happens when the research study stops?
The results of this study will be written up and submitted to appropriate journals for publication.

Who is organising and funding the research?
This research study is being organised by the Centre for Professional Practice at the University of Kent. This research does not require any funding arrangements.

If I have questions or concerns about this study, who can I contact?
You can contact me; my details are listed below for questions specifically related to this study.

Tracy Evans
tme6@kent.ac.uk
07904337895
University of Kent
Centre for Professional Practice
Research and Development Building
Canterbury
CT2 7PD

Appendix 17

RESEARCH CONSENT FORM

Name of Researcher(s)
Tracy Evans
Title of study
What influences women with sexual assault PTSD to disengage from therapy?

Please read and complete this form carefully. If you are willing to participate in this study, ring the appropriate responses and sign and date the declaration at the end. If you do not understand anything and would like more information, please ask.

- I have had the research satisfactorily explained to me in verbal and / or written form by the researcher. **YES / NO**
- I understand that the research will involve the researcher using information from my assessment, and I may be approached to conduct an interview, which will take no longer than one hour and will be recorded. **YES / NO**
- I understand that I may withdraw from this study at any time without having to give an explanation. <u>This will not affect my future care or referral to support services.</u> **YES / NO**
- Permission to use any direct quotations from interviews will be outlined to me in the first instance, in order that I am comfortable that I am not identified by those quotations. **YES / NO**
- I understand that all information about me will be treated in strict confidence and that I will not be named in any written work arising from this study. **YES / NO**
- <u>I understand that any material of me will be used solely for research purposes and will be destroyed on completion of your research.</u> **YES / NO**
- I understand that you will be discussing the progress of your research with others at the University of Kent. **YES / NO**

I freely give my consent to participate in this research study and have been given a copy of this form for my own information.

Signature: …….

Date: ……

Appendix 18

P1 Interview 29/01/16

T So um, tell me what your first feelings were about the charity, what was the, so you were invited to come for an assessment?

P I was, I was the one calling them, so ...

T You self-referred?

P I was self-referred, yes. It was the first, uhum, the whole process was a bit nerve wrecking from what I remember, and I remember because umm my incident happened two years before so it wasn't fresh.

T Hmm

P Um I went through a complicated situation, a complicated scenario, I was um I just arrived in London at the time so I was in very ... you know I was alone I was young I just arrived here I was a foreigner like you know I didn't have a support like in the sense I didn't know exactly what to do

T no support network?

P Um and when everything happened I went to an NHS clinic, like a walk-in clinic to get tested mainly and um to take the day after pill.

T Oh yes.

P Um, they ... from the bruises like I was held for 12 hours so it was kind of

T Really, that's quite difficult?

P Yeah. And so I was like covered in bruises there was a lot of stuff so there were conversations sort of came up with the doctors and the doctors at the time told me that ... they were a bit ... first of all they told me that if I wanted to like go to the police I had to decide right there right now because they were supposed to keep everything and they were very busy and it was like a walk-in clinic and they didn't have ... they weren't very prepared for that and so they pressured me at the time and then the doctor that was talking to me was kind of like you know this trial is like super long and they're probably going to say that it was consensual so it's a very difficult thing to choose about and at that time I said you know I just want to you know put it behind me ...you know ... I just arrived I wasn't going to start a massive ... like a month later I was like I'm not going to go for a trial or anything like that so I didn't go to the police and I sort of put the whole thing behind me and I didn't think about it for two years.

T Really?

P Yeah

T and you managed that?

P I ... yeah ... sort of, I mean I managed that ... the reason why I called the charity because in a sense two years after I started having other problems.

T Yes

P There were ...not strictly connected ...umm I started having problems ... I started having an eating disorder which is something that I never had before.

T and how did you understand that?

P the eating disorder?

T hmm

P Well, I went down to 48kilos so ... you know everything was so difficult ... like I was obsessive compulsive it was kind of like it was more about control than about the food I was obsessive and compulsive about everything. So my partner at the time was like there's something wrong you're obviously ... you know there is you know I'm very worried my mother was very worried everybody was very worried and I was like clueless like I was seeing all these people around me being very worried about me and I was like I don't get it yeah ok, and then one day sat down and I was like yeah ok maybe because I think they really wanted to meet that could have been related to you know what I umm really faced two years before. Which meant saying to people because they didn't know about it my mother didn't know about it you know no-one knew that I had been held captive for 12 hours in North London like that was something no known people that were close to me knew anything about. So it was a massive thing to just say ok I'll talk about this and I told my partner first and I told my mother ... and I actually told my mother after that I was already in touch with the charity. So I told my partner and my partner said maybe you should talk to someone.

T ok

P and I said you know I've thought about it for a while and I said ok. I mean I've never been I've always been very independent so I wasn't quite in the beginning I wasn't quite keen on like I've never been like I'm going to sit down and talk about my feelings [laugh] you know.

T ... asking for help?

P umm no not really yeah, absolutely yeah. So well you know it was fair to him and it was fair to me and I did it and then the whole procedure started to be absolutely ... because before managing to get in touch with the charity I went through at least two hours of phone

calls. Because I called ... I can't even remember what was the whole chain but I called one of the first numbers that came up for like rape you know help ...

T your first search?

P Exactly

T so the charity doesn't come up?

P It does but between a million other results and you have no idea so I called one of them and one of them basically said they were not taking cases they were not like ... the terrible part of the whole procedure is that every time you make a phone call they ask you what happened. So you go through like a number like a countless num ... umm times that you actually go through the whole thing on a phone call ...

T re-traumatising ...

P Yes! So here, what happened I was like I was err I was like ... getting frustrated and annoyed ... I mean two years ago this happened and blah blah blah and blah blah blah and I was like this is like the most difficult thing I've ever done.

T How many times did you have to tell your story?

P Six [eye-contact for a few seconds]

T And the real ... the beautiful part of it is the first person, like the first person the first time you tell your story they tell you oh sorry we don't take cases that are like not recent or someone says oh I'm really sorry for what happened to you but we don't have space and they refer you to someone else and give you another number so you call another number and they tell you oh we don't take ... we take only teenagers. And then you just go through this whole thing and they give you another number and at the end of the chain of numbers that I'd been given at one point was the charity. Which err, yes, and they err put me on a waiting list.

T Yes.

P And err, it was actually very quick to be fair, once I did the form on the internet I waited I think a couple of months, something like that.

T And then you had an assessment?

P and then I had an assessment, yes.

T What was that like?

P umm well it was like with the one that was going to be my counsellor.

T How did you know that?

P Because err I didn't know at the time, it just happened.

T Ah

P At the time I didn't know that she was going to do my counselling but it happened that she was the one that actually did my counselling. Umm ... and she was like a lovely lady and she was really nice but like the assessment in itself is very ... kind of a bollocks procedure in a sense because it's so like what they ask is like umm an endless sequence of questions that they give you the answers to like they give you options. And like it's like and sometimes the questions like how angry do you feel like very much not very much a lot like and I was at the time I don't even know if I'm angry like (laughs) it's not like something you can put in a box and say I'm angry at number 7 because first of all I don't know what's 10 and what's 1 so it's kind of hard ... it's like I'm angry at 5 or 6 (laughs).

T that's interesting

P umm but I mean I understand that it's kind of needed from what it will give you and she was very honest about it like before just as much it's not an entirely efficient form

T It's a history and the story and that's basically what we need, and she's right it's not particularly efficient.

P So I mean she was you know I was quite worried she was very honest it was what it was it wasn't traumatising or anything.

T It wasn't?

P No

T At the end ... when you left ... and once you left the assessment did you think I'm ok, that was ok?

P Yeah I mean like aside from the fact it was very ... the whole thing was very weird you know it's very weird to go two years after to a place and suddenly sort of start opening Pandora's box a very weird feeling I wouldn't say it was like traumatising I didn't you know leave the place and say I'm going to cry I was just like it was kind of a weird thing I mean what like she was very nice to me she said that like I wasn't I wasn't I was honestly my assessment was very good I mean was I wasn't having suicidal thoughts I wasn't harming myself the only thing that was worrying her was the eating disorder because that was the only thing that was you know sort of very immediately hurting my health

T yes

P so that was that was the thing that she sort of attached herself to in order to sort of put me up in the waiting list

T Oh ok

P so she was taking this to score me score a bit higher score me higher so that I could actually start sessions at some point because that was the only thing that she was worried

about was the eating disorder everything else I mean I umm I guess it sort of part of my personality I'm not a very emotional person I mean I am but I'm not like I'm sort of a bit controlled when it comes to emotions I don't like tend to detach myself more than get overwhelmed. So that's kind of like ... that's kind of like made enough difference ... that's thing she started to work on more which is that my natural instinct is to detach myself initially so she was like we need to you know you need to face the feeling you can't just say whatever.

T to feel your feelings ...

P so that was the work that she had me doing and I mean I felt that feelings over the following months so that fair enough ... umm

T How long were you waiting before you heard then so you said it was quite quick?

P it was very quick

T that's good to hear

P I think it was a couple yeah a couple of months.

T A couple of months, that's pretty good. So when a counsellor called you and said I've got a slot available for you to start counselling ...

P ... it was a relief because the procedure to get there was, I actually honestly generally think the procedure to get there was more daunting than the therapy itself it was like the wait and you know the phone calls and all that and sort of the bureaucracy of it was more problematic than the actual therapy so when they told me there were like you know we got a spot I was like oh that's cool at least I'm starting soon on something.

T So it was good?

P It was good

T It was a good feeling?

P It was a good feeling I was very nervous that day, very nervous.

T What made you nervous?

P Opening up to someone. Yeah. I'm not good at that. Like I mean I genuinely need even with normal people because I'm like this shallow like I like to push myself I think I'm a strong person that doesn't lack for anything so to sit down in a place and say hey I'm going to talk about how I am right now was kind of like no, I was like ... (laughs)

T It was tricky?

P Yeah (laughs) sorry to be like this but I was aware of it

T That's quite a transition

P Yeah definitely

T So the first session ...

P Yeah, it was actually, good I mean the only issue I mean it was very practical which was that the only spot they had was in (place name), which is far, it's really far because I didn't even go this way and they sent me to counselling all the way to (place name) which was an hour and a half.

T Did they do that because it was the first available slot and they wanted to get you started quite soon?

P I have no idea they never told me

T They never explained?

P No

T Ok, usually it's by borough and you request where you want to be seen.

P Yeah, I said that I was in (place name)

T Oh?

P They knew my address they knew my details but they never told me why they sent me to (place name)

T That's interesting

P Yeah, I don't know why maybe because there was like they had a slot there it was the same place where I did the assessment though because my assessment was in (place name) aswell they sent me to (place name) in the first place.

T Not here?

P No, this is the first I've ever been here

T right, ok

P Which Was?

T when you had the assessment did she ask you about certain boroughs that you could travel to did she ask you for a second and a third ...

P No she didn't she just asked me how you know how annoying it was to come there and I was like wow I mean I guess I can do it but yeah she never said like we could do that she just said

T No options. So did you say yes because you wanted to start?

P Yeah because if I had to go like in another, wait for another thing...

T ...for another slot to open in (place name)?

P yes, it's like I didn't even know if it was an option I didn't know it was an option at all because I never met anyone else in the charity except for my counsellor so she was the only person I ever met and went to the assessment she brought me for the assessment I went

to do the assessment with her and then she just told me I'll let you know when we can start and then she called me one night saying ok if you're fine we can start next week come here Friday and whatever time. So I didn't have the knowledge to mention there was an option there was another procedure I thought that was the way it was

T How long ago was this?

P Err not long ago it was this year. I mean I stopped counselling what like last summer.

T Yes so we would have had the same system in place. It's just unusual that's all.

P So, one of the reasons, I guess actually now we are talking about this the whole (place name) thing did play a role in my choice to end counselling.

T The travelling?

P The travelling did play a role and then it wasn't just about the travelling it was the fact that basically because it was on a week day in the afternoon and you know it took me you know an hour and a half to go an hour and a half to come back I was losing a whole Friday afternoon I mean I was basically losing a whole working day so and there was just an amount excuses that I could find and at one point I started having this real I think one of the reasons why like I mean I guess the specific reasons why I left counselling was more complex than this but one of them was that I started leading kind of a dull life because since I was given like basically an entire day of my life to counselling people around me, like not my partner other people my colleagues because my partner and I work in the same environment so our colleagues are our friends aswell umm all the people around me in my life all this started and saying I was disappearing every Friday you know what I mean it's like you know I reply and it's like a working day so like they were having meetings or sessions or whatever Friday I'd would say I can't can you do another day because on Friday I have, I'd sort of say that I was like having a sort of like having I need to see a doctor I have this and I have that and then at one point they just realised that I was like the boss keeps saying a different thing every Friday so I just said that I was having some health issues.

T ok

P and I had to go to a therapy on Friday.

T for health issues … … how many sessions were you offered?

P I don't know

T 16?

P I think it was around that yes

T 26?

P I don't think it was 26 I think it was 16 but it's like a feeling I remember someone saying like 16, yeah. So yeah, I mean the whole thing was becoming it was really becoming kind of nightmare to bring this whole secret thing that was taking like an entire day of my life away and I was producing two films at that time so was actually really busy and it was on the one side it was nice to have like to have a free day from the office and all that but the other side it was really weird to just loose a whole day and I sort of started getting into this thing where at some point it was almost like it was keeping ... it was holding me back more than because it's like you're moving forward with your life but one day a week you will do ... loose a whole day you will go back into your nightmares for like an hour you know what I mean it's just completely counter-intuitive and you have to have even more secrets because you can't say to people why you're losing half a day on Friday every week and it's like it's was kind of like the opposite direction of what I was trying to say which was to get out of the secrets and get out of like you know to move on while actually I was you know was just keeping up a lot of time and there being even more questions about it which was really counter to ...

T What was the ... so the first few weeks we'll say were fine?

P Yeah

T it started to get progressively more difficult when you had to try to explain the consistency of the Friday, the missing you on Friday?

P I think then in parallel with the fact that the more I started to actually ... the first half was fine because I was actually I had to it was like the [??] part of the therapy so I was genuinely feeling like I was working you know what I mean it was like I was doing something that I felt I needed to do so at that point I was fine like you know I had to leave and to lose half a day fair enough I need to get out of this then I'm the kind of person that does homework like I'm not going to just cry for an hour go home and forget about everything like if I do work for an hour then I'm going to bring it home and start working for the whole week so I progressed fairly quickly and when I started progressing ... when I started progressing then problems started because the more I was progressing the more forward I wanted to move and then went actually backwards the whole mechanical procedure was bringing me because of the Friday or because of the time.

T the functionality ...

P the functionality and

T were you bringing this to your counsellor?

P not really

T were you explaining that it was getting tricky this double life where on the one had you wanted to ...

P I don't think she ever asked me anything about it she never said she never asked anything about how the therapy was making me feel in the present like not like you know how is the work going yes that was asked that was a question but like she never asked me like what thing about the therapy on your current life.

T um and you didn't feel that you could say anything about that to her?

P I ... I never felt like saying that honestly because it was like ... I remember talking once about the fact that I felt like a bit the whole lie thing was getting important to me and I remember about the fact that she was talking about like you know maybe you should break down the lie like to your mother talk to your mother and like mentally it was like yeah well one thing is talk to my mother about rape but another is to talk to my colleagues like (laughs) like I'm not going to sit down with the directors and say hey by the way two years ago, that Friday thing oh that was so much fun ... I mean I don't think I'm going to do that (laughs) especially because it's like you know I guess I didn't think about err talking about it because it's like

T I wonder why

P I don't know I wonder why, me too

T I wonder what it was about, about that that stopped you from saying actually I'm finding it really tricky to try to juggle these things.

P I guess because I felt ... I kind of had to cooperate to certain rules

T I wondered that too

P It's like you know if because I'm not I guess I thought it's kind of the rule of the game you know if you if you if this is what they can you know if that's the spot they have that's the spot they have I can't go there and bitch about the fact that it's so far and it's like taking too much time because I was genuinely grateful for being there

T What do you imagine would have happened if you had said something like that?

P What she could have done anything about it

T umm

P I mean what I imagine is that she would have said I can understand your distress but this is the best that we have which was terrible by the way (place name) is the worst place on this earth it's so sad it's such a sad place it's like and it was like in a kinder garden and sometimes in the middle of the session like in the next room they were like singing songs and like screaming and I was like this is so ... God won't they shut up (laughs)

T Really

P Yeah so yeah I was trying to rise above that for an hour the the sound of the bumblebee was like being sung which was very very surreal it was very surreal it was such a surreal thing and it was like the fact that it was like in a kinder garden it was like a primary school or something it was really surreal that I was like basically walking through a primary school in order to get there

T Why was it surreal for you? Something about childhood?

P Well the first thing is because I always wondered what like you know all these people know the people that are walking in for the school like they know if you're a teacher if you're not a teacher if you're like a parent like they know these people. So like I was wondering I can remember the first time I was actually really nervous because they gates were closed when I arrived and I was like how do I get in. And I had to buzz at a primary school and then the when I buzzed to let me in what am I going to say? I have to cross your yard? (laughs). I can't remember what I said but something like I have a meeting in the after-day care or something I can't remember the place I have a meeting there was a long silence and then someone let me in and it's like ok they didn't ask anything.

T Was it explained to you beforehand about getting into the venue?

P No, no I actually couldn't find it for a while because it's like I could find it but I had to like ... I wondered for like a good 10 minutes if I was going like in the direction of the reception there, and I was there with my partner the first time, he came with me. So I remember being on a bench sitting on a bench with my fiancé and he was looking at the primary school and saying is this for real here is this the place? And I was like I have no idea he was like some sort of hospital or clinic or something and where am I going to find it and where am I supposed to go. So the whole set-up was very weird.

T and you weren't informed about any of that beforehand?

P No, I didn't know

T maybe had you been a little bit more prepared for where you were going could have ...

P yeah maybe the first one, the first one yes I mean after a while I got used to it. The first one yes, and umm I didn't have any clue about.

T So, time was moving on, how many sessions in before you started thinking about ... it was becoming ...

P how many sessions before I started thinking about maybe to stop this ... one (laughs). But because like

T how many sessions did you attend?

P I think about 10

T of 16

P 10 or 12 something like that

T ok. But from around the first session?

P Yes, because it was coming from different places at different times. Like at the beginning it was general generally the beginning like God I have to fucking I have to go there every freaking Friday thinking and talk about stuff like that and you know

T and that's what ... is it daunting the idea of going over that stuff?

P For me it's absolutely terrifying I mean it's like it gets to different people have different reactions to it like I never been good at like I mean I'm not it's like for me you get very used to sort of keep it for yourself yeah if that makes sense because you can't you get used to getting sure

T you manage that yourself

P Yes, and there's like the whole personally I guess I made that way but for me it's very very hard for me to go to someone and say I'm hurt or like I'm suffering or I'm in pain it's very humiliating for me. So in the beginning it was justified that I was generally that uncomfortable but there were the positives where still stronger because I was actually doing better I mean I was doing worse but it was making sense, you know what I mean I was doing much worse which meant that I was doing better

T Yes the process ...

P Yes. So I was kind of like as hard as it is it's something I have to do it all the beginning was kind of like as much as I was saying to myself I might just quit

T so you're saying this is something good for me even though it's quite painful I can do this for me

P Yes

T so where are we, week three, four

P six I think from week seven after like going it was like a graph or something you know after week six or seven I was sort of on a curve that was going up and then I think and then flat and then I started going downhill. And the moment was when I felt I wasn't moving forward anymore in a sense like

T why did you feel that? what was it that ...

P I actually didn't feel like I wasn't moving forward I felt like I wasn't doing anything that I couldn't have done myself

T Right

P and at that point I was like why am I wasting a whole day thinking like how's this and why's and in my head when I could technically do myself

T Could you say a bit more about that ... what could you do yourself?

P I mean, I hate I don't want to sound cocky or anything like that, but once I have the pieces of the puzzle going to therapy is sort of becoming more like getting nearer bringing the puzzle sort of a piece more and I did this and hearing someone say that's really good ... for an hour. And I'm like so? And a week after I'd bring another piece and she'd say that's great. And I'd say thanks.

T umm, something about you feeling that you had reached a place where that was ok, that many sessions was ok?

P I'm not sure about that.

T Can you say more?

P I mean I'm still not sure about that because I mean the process is not I mean I'm so better I'm so much better than a year ago like if I take myself a year ago and take myself now – two different planets. I'm eating, it's still something if I'm very nervous if I'm very worried or like stressed there are periods of stress I get less hungry or I lose appetite I'm a bit more like I don't feel like eating but it's sort of just pushing myself you know what I mean just not beat yourself up but umm I don't think and I don't think I was thinking of the last session in the last couple of months thinking it was my fault I'm asking myself if it will ever be ... I'm a different person than I was three years ago. There are some things about myself that I have never experienced before like I've never been an anxious person I've never had panic attacks I've never been depressed

T did that all present itself after the assault?

P Yes. I mean I've been in very difficult situations in my life and I've been very sad and I've been very tormented and such and had a different attitude to it. I was almost rebellious before the assault. So I wasn't the person depressed and you just want to lie in bed and never get out I was kind of depressed and going to a party and kicking and punching someone you know and exploding and making a mess. The mood swings the feelings of worthless, that stuff never happened to me it was a completely different world from what I know myself as and as much as it got better it's not over completely like there are some aspects of it that are still there I still sometimes go very low phases my mood can change pretty quickly even if it's better than before there are still parts of my personality that I would like it kind of almost feels like having control of my mind sometimes my mind just goes boom just on the side and you're like what what's going on and it's like in a way that I've never experienced before so

I'm asking myself how much of that is my new reality and how much of that something that I'm going to actually get rid of completely. I mean where does my personality end and where does my trauma start at this point

T it's not a process in itself it's an ongoing process even if you had stayed and had 16 sessions you would still have that ongoing process about coming to terms with that part of your life. There is pain and change and change is difficult and learning different managing skills

P So in a sense it's like I never came to a session to counselling and said I'm fine I'm healed and I don't need sessions anymore that you know a process but it wasn't at one point I felt I didn't need it anymore the process I was going through it was more what I was doing myself than what I was actually doing in the session and going losing a whole day for that

T what was she not doing, what could she have what would have made the difference between your leaving and staying?

P I think that, I mean I genuinely respect that woman very much I genuinely appreciated the time that I spent with her I never had that relationship with a counsellor or anything like that but I think that we were incredibly different as people and I was very practical I'm very practical I need to do things I need to have the feeling I'm actually doing something I'm not contemplative and I cannot sit and observe I can't just ... I'm not even sure if it's possible or not but like I need as a person I need to sit down and feel like I'm actually doing something to solve the issue which sometimes not just sometimes like talking about how you feel about things doesn't give me that and as much as I had to learn how to talk about feelings once I started doing it I guess I hoped that we would do something different aswell like once I opened I cried in session like I have never cried in front of anyone after I cried in a session it was really emotional I was like can we start doing something in a way and I guess that in the last moment she would have been more positive proactive almost I kind of had the feeling that she was just going to sit there and wait for me to tell her what happened last week or what I didn't do since last week and how that made me feel and part of the session was always the same

T what kind of proactive would you have appreciated? What sort of things? Do you mean skills, managing skills?

P Yeah but also rationalising

T Can you say more about that?

P It's not about I mean I'm not a psychologist so it's really hard to say I mean even just writing down things putting it on the table some physical things to do would have completely changed my attitude you know what I mean

T I understand

P It's just that talking session that sort of feels so suffocating almost.

T Did you say that to her did you feel able to say that to her?

P No, I didn't feel like I had the knowledge to say anything like that she's the expert not me I sit down and say like I'm not a psychologist. My mother was a volunteer with mental health patients and she was doing art therapy so I guess I took it from her I kind of need at some point I guess I absolutely understood why she wanted me to talk and open up and I was fine doing it and I absolutely fine about the fact that I had to go through an emotional journey because I'm not used to it and once I've done it I wished there was something instead of falling into the void

T Is that what it felt like?

P Yes, it just felt like I poured out everything and nothing happened and it just fell on the floor, so once I've done I was like now what? What's going to happen I just opened my heart

T Was that difficult?

P it was more frustrating

T What session are you in now

P I think five, six, seven

T What was that like to have to manage that

P I was very frustrated I was insanely frustrated

T still somehow no sense of being able to say I'm finding this process frustrating

P because I thought that was the process like I never thought that things were or could have been different

T that they could have been tailored towards what you might actually benefit from

P Correct. I never knew there was another way of doing it I just thought that was the way of doing it and I guess I assumed the frustration was just a part of it. But I'm thinking I was really frustrated angry frustrated I started treating my partner like terribly there was a moment around week 7 or 8 where I had genuine issues and that's one of the most emotional sessions that I had because I growing so frustrated I mean I doubt it was all about sessions or the therapy it was the mixture of therapy having to deal with all this stuff I got so frustrated I started to control my rage and there were moments where my partner was like I remember

being very aggressive towards him once because he picked up a grocery bag for me ... and I was carrying two grocery bags I felt horrible I have to say I was really sorry I mean he wanted to be close to me and I understand it. After two or three months like that it was putting me under a strain he picked up a grocery bag when I was carrying two and I felt offended by it in a very rage form or irrational way I felt offended because I felt he thought I couldn't do it myself. In that moment emotionally I felt horrible after when I calmed down I was like I'm completely insane because I can't believe that I did this but in that moment something just clicked in my head it was like all the frustrating boiling up just broke and when he picked up that bag I just screamed and I was like I can do it myself he was I can do it myself he was terrified

T but not at any time were you able to translate that in some way to your counsellor

P I mean we talked about my frustration and we talked about my rage we talked about that

T Did you talk about ... it might be somehow to do with your frustrations or something else

P I think that she told me, I think I got the feeling from her that was a normal process like I think I got the feeling from her that was a more feeling ... to feel you know like talking and doing the sessions and therapy about something so personal is obviously traumatic and like every time you give the trauma the frustration is part of it and there are moments when you feel like ... and I accepted it you know I was like she probably knows more about it than I do. So I never quite thought again I didn't know things could have been done differently I just assumed that was the way they were so I didn't back then I didn't think in my head oh it's probably because the therapy is not working I genuinely just thought that was part of the process I guess now like months later I'm starting to place things together for like ... cool minded ... later.

T But the counselling is actually for you. The sessions are yours.

P So I could have technically had them in the direction that I want?

T Yes

P I mean, I guess I knew they were for me but I didn't know that I could ...

T It's difficult for a client to voice that once the therapy is set up, and you have hit on something that's quite difficult for a client to voice. Like, this isn't quite what I want I don't quite know what I want but it's not this, can we talk about some other stuff that may be good for me?

P I don't think I had ... I have so much stuff in my head, that I don't think you can ... because I guess it's a big step to trust someone it's a huge step to go in a place and trust that person that you're going to talk about ... that like the idea of questioning like going to a place and question that and you do it actively and you do it in a positive way I don't think I mean I think it's a huge step because you have to question the trust that you had to create without destroying it by turning it into a different direction and that's like that requires a [ ]

T Is that what the fear is about that the trust will be questioned and then you won't be able to do anymore therapy anyway?

P Yes, yes.

T That's quite important. So, what session did you leave and did you talk to your counsellor about it?

P Well I did, I mean I left I was going to have a bunch of weeks that I was going to be very busy because I was going to shoot a ... I was going away to shoot a couple of films so I wasn't going to be physically in London so I think the only week I was in London my therapist wasn't so there was going to be like a break anyway a gap anyway. Actually I have no idea how many sessions now that I think I can't remember if there were 9 or 10 I can't remember how many I did but umm so there was going to be a gap and before the last time we were seeing each other before the gap I already told her I was thinking about quitting.

T You did. Did you say why?

P I said because you know because I felt like I can't remember I definitely said because it was getting very busy with work and I couldn't afford to do the Fridays off that much anymore.

T Was that the whole truth?

P No it wasn't the whole truth.

T Because the whole truth would what?

P The whole truth was that it was kind of a balance thing, it was you know I mean I feel like we weren't going anywhere.

T And that would what?

P I guess that I would have offended her (laughs) I was like I'm not supposed to say that.

T Exactly.

P Anyway there were things I was going to be very busy and at the same time I felt like I was in a better place and I could ... that's partly true.

T So up to that point that you had what sort of benefited from the sessions that you did have?

P Well it definitely ... it definitely helped me I mean from someone like from the whole process just partially accepting what happened in first place it was huge to just first of all it was huge to just remember some details of that night because when I came there I was coming with like just very partial memory I had very I still have very partial memory but I was coming there with almost six 7 hours of gap like I blocked like complete like I had to generally like take flashbacks and if they were true if they made sense and place them on a timeline to understand what actually happened the whole process happened in therapy so in that sense it's really useful because it made me face what happened with ... you know sort of reconstruct what actually happened and understand that it wasn't my fault which was one of the things I was bringing with me in the beginning of the sessions because part of me felt very guilty for what happened to me because umm I'm a very controlling person and umm that night I did something a bit naive I decided to let it go and I did something a bit naive and I did something that if I think rationally about now I'm like that's stupid that is a stupid thing to do but because there is something I consider that I still consider if someone else tells me I'm going do this I'm going to be like are you stupid or something because you know what I mean it's like when someone tells you something and you do it but when you do it in that moment I was chatting with people

T you can see that now, here

P but back then I was hating myself because I was like it's like it was my fault I did something absolutely idiotic and like I was putting all of the blame on myself so in that sense reconstructing the whole picture and understanding that they were they planned this so it wasn't just doing you know just being in the wrong place at the wrong moment this guy just planned the whole thing in advance so it was kind of relieved that's for sure and managed to take distance from that and it was useful to dealing with feelings which I haven't done before so like I feel you know rage or pain or vulnerable all that stuff I wasn't really I didn't want to do it before and I kind of had to go through that with therapy which was very useful

T So there were benefits

P There were definitely benefits definitely but there was like a moment when you know benefits and disadvantages and that was when the problems started in a sense.

T What was the closure like?

P well before that break that we had I told her that I was going to think about doing the break because I was very busy and we weren't going to see each other for like three weeks or something anyway

T There was a gap of three weeks, and you already told her the week before

P The week before the gap I told her I was going to use the three weeks to think about umm you know how I was going to use the three weeks as kind of a test to see how it goes without therapy and not think about it and I'm counting the session in three weeks at that point you know we can decide or I can tell you what decision I make and that's how it went I came back and said that was going to be my last session.

T What was it like?

P A bit awkward you know very awkward.

T For you?

P I think for both of us. I genuinely think for both of us. Like I remember like we were very friendly with each like we were always very friendly with each other and we were very friendly that day as well but it's kind of more a friendliness you know when you're like saying goodbye to someone and you're not sure if you want to shake hands or if you're supposed to hug someone or like give them a thank you ok or shake her hand I don't know it was just very awkward and like she didn't know how to behave I didn't know how to behave so like it ended up like ok thanks take care and I left. So awful. Yeah, it was a bit awkward

T hmm

P I don't know why actually

T Can you think about what that might be about?

P I guess because it's kind of its such a weird relationship it's not like ... you have this person that you don't know at all that knows a lot about you and you talk with her but you're not like into a ... start believing that you have a relationship with her but then when that breaks because you say you're not going to do therapy anymore the whole spell breaks and you're like this is a stranger again like and at that point when she was a stranger again I don't even know how to address her like suddenly when she wasn't my therapist anymore I was leaving the room I was like I genuinely don't know if I have to shake her hand or if I have to be more friendly at one point I was like I'm terrible at physical contact with a stranger like really bad so I was like should I hug her and like she didn't do anything I was kind of waiting for her to give me like ... because I was like she didn't do something like she would not shake my hand or give me her hand or something so that I can say ok I'll shake hands and she didn't and so we had no physical contact at all

T Must there be?

P I guess yes I wasn't needing a physical contact the only thing is like because it fell into that awkward standing in front of each other and like no one did anything it's not that we genuinely it's not that we can't decided that we can't shake hands or anything it's just that no one knew what to do so no one did anything in the end I just left and was like that was a bit weird

T hmm ... what were you feeling? What do you think that that's about? For example, I'm doing the right thing; this is the right thing for me. Or were you thinking about what the counsellor might be feeling or thinking about

P No, I didn't think of what she was feeling but because I told myself that's what I want.

T The three weeks in between had you more or less made up your mind that that was going to be it

P I honestly feel I made up my mind before the three weeks I genuinely think that when I went to that session I knew that I was going to [ ] it

T What's that about, is that an obligation that you felt?

P I guess I guess I don't know maybe a part of me wanted to I actually genuinely think that was the first time that I said it for her, more than for me

T Yes, that's what I meant about the awkwardness

P I genuinely felt that was for her

T You wanted to take care of her?

P Yes

T You were taking care of her feelings. Why?

P Because she was very cute (laughs) like she has kind of like I'm sorry. I think you're a lovely lady you really are

T You're a lovely lady, but?

P But, (laughs) I guess yeah it felt like a bit bad I guess that I don't know but when I came back three weeks after and we started the session I had the feeling that she didn't really think that I was going to leave you know what I mean I don't think that when we met the three weeks after and we had that session I don't think she I actually think she thought ...

T you would go on?

P That I would go on

T Why did you get that feeling from her?

P Because she was sort of like very much like usual. So the whole session sort of went very like we would go if we didn't have that conversation before so at that point I guess I was initially like should I bring it up (laughs) or should I remind her that I'm leaving therapy

T So she didn't bring it up?

P She brought it up in the end

T At the end?

P Like at the end of the session she was like so how did the break go like how did your thoughts go did you think about what you wanted to do but at that point it was terrible because we had been through the whole session it was like aaggghhh

T Was there a sense of her avoiding it or you avoiding it?

P I was ready, I was ready to move you know I was like when I stepped in I was like ok let's have this conversation I was almost like surprised that didn't happen like I walked in and I was like this is how I expect it to go now and then to sit down and then she would say so why and I would say sorry

T So you didn't have a closing session?

P No

T That's interesting it didn't happen

P No, it didn't happen in the session

T I imagine that's some of the awkwardness and some of your feeling that you needed to look after her a bit and

P I know what the feeling is I know exactly what feeling it was when I was a teenager when I was dancing when I was a teenager in competition sometimes the teacher would give us choreography and stuff like that for competition that we weren't sure that we were going to because you know you might have someone injured and you might have to step in and you need to know the choreography anyway even if you don't do it there were times my teacher wasn't exactly sensitive in telling things like she was a bit strict and a bit like rough she was (place name) I guess that was the reason (laughs) and err I remember being 14 and standing like five hours 6 hours in the studio learning a choreography that was like I remember like hating it there because I was really good I was very flexible but I wasn't like really strong like like fast paced stuff I remember having huge problems with fast pace choreography and that wasn't kind of my thing so I remember doing this thing it was a lot of work and I remember banging my head against it was terrible and I finally learned it and I was like yeah I finally managed to and she just walked in and she said how are you doing and I like cool cool I've learned the choreography and she was like oh yeah you're oh not having it this

week and I was like (laughs) I remember that the feeling was so anti-climax so anti-climactic and it just happened so like oh ok I wasn't really sure what to feel and I kind of guess I had the same feeling in the last session a bit anti-climactic because I got there and I thought we were going to talk about it and then we didn't and so I was leaving and I just left and I was like what just happened?

T So you didn't really have a closure?

P No

T You just left a session that was running normally until the end

P Yes

T Hence your discomfort I would imagine? It explains a lot and the dancing anecdote explains your feeling

P Hmm

T Would you um think about having counselling again?

P That's a tricky question, that's really hard to answer it really is for a number of reasons

T Is it the reasons we have gone over in this last hour or is it more to do with unearthing quite a lot of stuff for you again, returning to something ...

P I think I mean part one and part the other I mean partially I guess like on the practical side I would consider it only in certain conditions I mean I would consider only if it was affordable and decent times I wouldn't go through the whole (place name) experience again like assuming that the practicalities were there I guess then my issue would be then my question on one side I genuinely am doing better overall I had a very the only reason the only thing I'm divided because I had one very very low episode about 10 days ago very recently if this meeting was happening a week ago I would have said no I mean I would have said no I mean a week ago I had a very scary low to me like I was genuinely scared and it kind of came out of the blue because after like of bunch of months where I have been doing a lot better and I'm eating and all that now I'm in a phase where I don't feel like eating that much and I'm forcing myself a bit but I don't have the motivation sometimes I skip lunch and then I force myself to eat lunch but um I'm not training compulsively like I went back to dance like I'm dancing with a lovely company like right now so which helped because you know I can I'm not stressing myself into things that I'm not comfortable with I love it it's a good feeling aswell so overall I'm doing a lot better on the other side that low a week ago that was really scary that was genuinely like things are not right

T When you're in that sort of place is that when you think perhaps I might need counselling?

P I felt it right after actually like when I got out of it I was so ... that was ... because I think I sort of placed it in the very low moment you know I placed in the area of

T Did you consider that it might have been triggered by my contacting you?

P I'm not sure I can't say I really can't say because it was triggered by so many other factors going on

T I appreciate that, but we couldn't rule out

P I couldn't rule it out this but I couldn't rule in for sure because my mother had a heart attack my mother was very sick and had a heart attack in Italy and I couldn't go back because I'm working on a thing that I'm going to show in a couple of week which has actually been it a project I've been working on for a year now and it's complex it's one of those projects that it a short film that put me in a corner a number of times and creatively I mean the results are about abuse so it's kind of like a sensitive topic for me and you know when you have to create something that's so close to what you experienced and that while you're talking in therapy and rolling the tape on and writing the script it's a lot going on so you know I was having difficulty with that last week it's a very strong moment where the film wasn't going the right way and my mum wasn't fine and I got so there was a lot of things actually going on and you know you contacted me at the same time so it was kind of the same batch of stuff going on but it was quite scary like the level of unresolved stuff that I was feeling like flashbacks back in the day

T So when things are all ticket boo and you're like working well it doesn't occur to you think about until something shifts in you and then you think perhaps I do feel better

P The question is how much of this is my new reality how much of this is going to be this way from now on like it's going to be managing all these things a bit and how much is like or how much would it help to do more therapy or actually learning to juggle these things from now on I mean I'm not happy about it but it's not great ...

T Some self-managing through it is pretty good if you've got the skills and you feel that you can get through something is pretty good

P Yeah definitely but like that was like if you were asking the same question before that the answer would be no

T So no real definite answer?

P I don't think there is a definite answer I mean not right now, no

T Thank you very much

Appendix 19a

Developing Emergent Themes
Exploratory Comments Identified from P1 Mira

Exploratory Comments Key	
Normal text	Descriptive Comments
Italic	*Linguistic Comments*
Underline	Conceptual Comments

Emergent Themes	**Line #**	**Original Transcript Extract**	**Exploratory Comments**
Fear of remembering Time period is important	115-135	P Yeah I mean like aside from the fact it was very ... the whole thing was very weird you know it's very weird to go two years after to a place and suddenly sort of start opening Pandora's box a very weird feeling I wouldn't say it was like traumatising I didn't you know leave the place and say I'm going to cry I was just like it was kind of a weird thing I mean what like she was very nice to me she said that like I wasn't I wasn't I was honestly my assessment was very good I mean was I wasn't having	*Repetition of the word 'weird'; followed by 'opening Pandora's box';* emphasises feelings of discomfort, confusion, or fear about the struggle to return to something frightening in the past. Sense of time, P1 returning to a traumatic event more than two years prior to therapy. Is P1 ready to look at it, and begin to come to terms with it, now? Has there been enough time for her?

Avoidance Self-harming How coping Sense of self: controlled, detached Defended/protecting self		suicidal thoughts I wasn't harming myself the only thing that was worrying her was the eating disorder because that was the only thing that was you know sort of very immediately hurting my health T yes P so that was that was the thing that she sort of attached herself to in order to sort of put me up in the waiting list T oh ok P so she was taking this to score me score a bit higher score me higher so that I could actually start sessions at some point because that was the only thing that she was worried about was the eating disorder everything else I mean I umm I guess it sort of part of my personality I'm not a very emotional person I mean I am but I'm not like I'm sort of a bit controlled when it comes to emotions I don't like tend to detach myself more than get overwhelmed so that's kind of like ... that's kind of like made enough difference ... that's thing she started to work on more which is that my natural instinct is to detach myself initially so she was like we need to you	Shifting the focus on to food since the assault, <u>something that P1 feels that she *can* control</u>? <u>If counselling links the eating disorder back to the assault, what might be opened up that she cannot control?</u> Self perception: 'not a very emotional person ... I'm a bit controlled ... detached'. <u>Foreshadows a sense of herself that she brought to therapy, already sensed the possibility of the difficulty of what therapy might bring up, defensive approach for self-preservation</u>

		know you need to face the feeling you can't just say whatever	
Recognition of anxiety beginning of therapy Difficult to acknowledge vulnerability to self and others Sense of self: a strong individual with drive and ambition Fragile self Mask of confidence	149 - 159	T So it was good? P It was good T It was a good feeling? P It was a good feeling I was very nervous that day very nervous T What made you nervous? P Opening up to someone yeah I'm not good at that like I mean I genuinely need even with normal people because I'm like this shallow like I like to push myself I think I'm a strong person that doesn't lack for anything so to sit down in a place and say hey I'm going to talk about how I am right now was kind of like no I was like ... (laughs) T It was tricky? P Yeah (laughs) sorry to be like this but I was aware of it	Foreshadow of anxiety of what therapy might bring up for her Does not 'open up' to people. Only allows people to see strong, driven and confident aspects of her personality. Being vulnerable linked to a fragile self-esteem: not confidence and strong and ambitious Aware that she performs in her life: her public and private self are conflicting realities for her

Difficulty of travel time and inconvenient venue location Unsettling the safety of her work schedule Impact of therapy on her work routine Colleagues might find out (see through her?) Self as performance	202 – 220	P So one of the reasons I guess actually now we are talking about this the whole [name of borough] thing did play a role in my choice to end counselling T The travelling? P The travelling did play a role and then it wasn't just about the travelling it was the fact that basically because it was on a week day in the afternoon and you know it took me you know an hour and a half to go an hour and a half to come back I was losing a whole Friday afternoon I mean I was basically losing a whole working day so and there was just an amount excuses that I could find and at one point I started having this real I think one of the reasons why like I mean I guess the specific reasons why I left counselling was more complex than this but one of them was that I started leading kind of a dull life because since I was given like basically an entire day of my life to counselling people around me like not my partner other people my colleagues because my partner and I work in the same environment so our colleagues are our friends aswell	P1 cites the difficulty of travelling to the venue as *one* of the reasons for disengaging from counselling early, and the impact on her work schedule initially. *Repetition of 'did play a role', important to P1 to have a concrete reason for disengaging from therapy* *Started leading a dull life':* <u>safe, consistent and routine daily work life established. The complexity of returning to a traumatic even, what feelings that might engender in P1 that might undermine that safety and security she has achieved. Not wanting to challenge the status quo, perhaps.</u>

		umm all the people around me in my life all this started and saying I was disappearing every Friday you know what I mean it's like you know I reply and it's like a working day so like they were having meetings or sessions or whatever Friday I'd would say I can't can you do another day because on Friday I have I'd sort of say that I was like having a sort of like having I need to see a doctor I have this and I have that and then at one point they just realised that I was like the boss keeps saying a different thing every Friday so I just said that I was having some health issues T ok	Overly concerned with and a little paranoid about what others will think if they find out where she is going and why? Self-pressure to maintain the appearance of 'normal' at work, having to perform for others is dishonest self-view: multiplicity of discomfort for P1 to continue therapy and risk disclosure of assault

Beginning to remember – language shift to fear? Denial/repression of assault Inability to be vulnerable; too humiliating; too much like feeling powerless	327 – 343	P Yes because it was coming from different places at different times like at the beginning it was general generally the beginning like God I have to fucking I have to go there every freaking Friday thinking and talk about stuff like that and you know T and that's what ... is it daunting the idea of going over that stuff? P For me it's absolutely terrifying I mean it's like it gets to different people have different reactions to it like I never been good at like I mean I'm not it's like for me you get very used to sort of keep it for yourself yeah if that makes sense because you can't you get used to getting sure T you manage that yourself P Yes and there's like the whole personally I guess I made that way but for me it's very very hard for me to go to someone and say I'm hurt or like I'm suffering or I'm in pain it's very humiliating for me so in the beginning it was justified that I was generally that uncomfortable but there were the positives where still stronger because I was actually	*'stuff like that'*. P1's realisation that therapy *is* the stuff that has been avoided for over two years. *The language shift: 'God', swearing, 'freaking' getting in touch with memories of the assault again?* Therapy is terrifying because it is a return to the terror of assault. Feels important that the memory stays hidden. Intrapsychic process implicit: thinking about not thinking about the assault *'keeping it to yourself'* *Repetition of 'very': counters P1 self view of being 'controlled and detached'*. Inability to be vulnerable in therapy, perhaps echoes the terror of powerlessness and vulnerability of assault? *What is 'humiliating'?* The assault or revealing her suffering as a result of the assault? *A measure for healing and change in therapy 'things get worse before they get better'. Some comfort for*

Needing a tangible measure of progress – detached from feeling Always thinking of escape, won't get trapped this time Intellectualising Losing a whole work day for something she could do herself? Justification for leaving. Doing not feeling – I can heal myself. Flight in to health	393 - 427	doing better I mean I was doing worse but it was making sense you know what I mean I was doing much worse which meant that I was doing better T Yes the process ... P Yes so I was kind of like as hard as it is it's something I have to do it all the beginning was kind of like as much as I was saying to myself I might just quit P So in a sense it's like I never came to a session to counselling and said I'm fine I'm healed and I don't need sessions anymore that you know a process but it wasn't at one point I felt I didn't need it anymore the process I was going through it was more what I was doing myself than what I was actually doing in the session and going losing a whole day for that	*P1initially in therapy as an indication of her progress, perhaps.* *Something she had to do but all the while thinking to herself I might just quit.* So, if therapy feels really bad the option to leave is always there. Important for P1 to have the control or power to make that choice Give me something to *do* not something to *feel* *Repetition of genuinely: genuinely respect / genuinely appreciated.* Trying to impress her feelings as genuine is somehow important but feels counter-intuitive and creates doubt instead. Easier if it is something the therapist is doing/not doing, rather than something about P1, that makes her wants to leave therapy?

There is something wrong with therapy/therapist, it is not working Doing not feeling Self view as practical not contemplative (intellectualising feelings) Language of feelings need to be learned		T what was she not doing what could she have what would have made the difference between your leaving and staying? P I think that I mean I genuinely respect that woman very much I genuinely appreciated the time that I spent with her I never had that relationship with a counsellor or anything like that but I think that we were incredibly different as people and I was very practical I'm very practical I need to do things I need to have the feeling I'm actually doing something I'm not contemplative and I cannot sit and observe I can't just ... I'm not even sure if it's possible or not but like I need as a person I need to sit down and feel like I'm actually doing something to solve the issue which sometimes not just sometimes like talking about how you feel about things doesn't give me that and as much as I had to learn how to talk about feelings once I started doing it I guess I hoped that we would do something different aswell like once I opened I cried in session like I have never cried in front of anyone after I cried	*Self-view of her personality as practical, not contemplative or sitting or observing* but 'doing' not 'feeling' *Had to learn how to talk about feelings.* Sense of difficulty for P1 to remain open and vulnerable in therapy Sense of a lack of safety or holding in therapy? Inability for P1 to be vulnerable there? Something of repetition in therapy that feels contrived or unhelpful. P1 not convinced by the 'mechanisms' of therapy. Struggling when asked about her 'feelings' each week '*part of the session was always the same'* *Rationalising = logical.* Intellectualising as a defence to shut off feeling. Something in therapy has shifted, no longer induced to *feel* her feelings

Remembering and mourning feels unsafe Proactive - not feeling Rationalising - not feeling Feelings are too unsafe Talking (remembering) is suffocating her		in a session it was really emotional I was like can we start doing something in a way and I guess that in the last moment she would have been more positive proactive almost I kind of had the feeling that she was just going to sit there and wait for me to tell her what happened last week or what I didn't do since last week and how that made me feel and part of the session was always the same T what kind of proactive would you have appreciated? What sort of things? Do you mean skills managing skills P Yeah but also rationalising T Can you say more about that? P It's not about I mean I'm not a psychologist so it's really hard to say I mean even just writing down things putting it on the table some physical things to do would have completely changed my attitude you know what I mean T I understand P It's just that talking session that sort of feels so suffocating almost	*Talking about the assault is suffocating, or talking to a therapist about the assault is suffocating?* A red flag? Perhaps an indication of anxiety or panic reminiscent of the assault, of feeling trapped. P1 might be projecting these feelings on to her therapist as a way to distance and withdraw and ultimately stop talking *She's the expert / I'm not a psychologist.* I don't want to tell her what I need, what I feel, what I think. Therapy feels unsafe (suffocating), fear that it might give rise to a worsening of feelings/mood P1 understands cognitively (intellectually) why therapy begins an account of the assault but wants another option, one that avoids her *falling into the void*. What is the void and emptiness that P1 begins to experience in therapy? A defence mechanism to feel nothing and numb. A disconnect from herself (feelings) and others (the therapist) as a protective measure: a psychic distancing (split) from the suffocation (trapped-ness) of remembering? How

Resisting communicating her feelings (vulnerability) to the therapist – fear of powerlessness Feeling empty as a response to loss that cannot be tolerated/integrate		T Did you say that to her did you feel able to say that to her? P No I didn't feel like I had the knowledge to say anything like that she's the expert not me I sit down and say like I'm not a psychologist my mother was a volunteer with [health service organisation] and she was doing [name of profession] so I guess I took it from her I kind of need at some point I guess I absolutely understood why she wanted me to talk and open up and I was fine doing it and I absolutely fine about the fact that I had to go through an emotional journey because I'm not used to it and once I've done it I wished there was something instead of falling into the void	does the space get filled, now? Loss: something that cannot be communicated to the therapist?

Appendix 19b

Table of Subordinate Themes and Related Emergent Themes P1 Mira

Subordinate Themes	Emergent Themes	Sample Transcript Extract
Recognising the need for therapy	Not coping Time period is important Getting lost in the health care system Retrauamtising journey to finding the right support Minimal support network Developing PTSD symptoms	I ... yeah ... sort of I mean I managed that ... the reason why I called the WS because in a sense two years after I started having other problems (P1, lines 33-34) ... first of all they told me that if I wanted to like go to the police I had to decide right there right now because they were supposed to keep everything and they were very busy and it was like a walk-in clinic and they didn't have ... they weren't very prepared for that and so they pressured me at the time and then the doctor that was talking to me was kind of like you know this trial is like super long and they're probably going to say that it was consensual so it's a very difficult thing to choose about and at that time I said you know I just want to you know put it behind me ...you know ... I just arrived I wasn't going to start a massive ... like a month later I was like I'm not going to go for a trial or anything like that so I didn't go to the police and I sort of put the whole

		thing behind me and I didn't think about it for two years (P1, lines 20-29) ... the beautiful part of it is the first person like the first person the first time you tell your story they tell you oh sorry we don't take cases that are like not recent or someone says oh I'm really sorry for what happened to you but we don't have space and they refer you to someone else and give you another number so you call another number and they tell you oh we don't take ... we take only teenagers and then you just go through this whole thing and they give you another number and at the end of the chain of numbers that I'd been given at one point was the WS (P1, lines 78-84) I mean was I wasn't having suicidal thoughts I wasn't harming myself the only thing that was worrying her was the eating disorder because that was the only thing that was you know sort of very immediately hurting my health (P1, lines 119-122)
Getting in touch with vulnerable self	Sense of self: controlled, detached Defended/protecting self Anxiety beginning of therapy	I mean I umm I guess it sort of part of my personality I'm not a very emotional person I mean I am but I'm not like I'm sort of a bit controlled when it comes to emotions I don't like tend to detach myself more than get overwhelmed (P1, lines 129-131)

	Difficult to acknowledge vulnerability to self and others Sense of self: a strong individual with drive and ambition Fragile self-esteem Fragile contrived confidence	It was a good feeling I was very nervous that day very nervous (P1, line 152) Opening up to someone yeah I'm not good at that like I mean I genuinely need even with normal people because I'm like this shallow like I like to push myself I think I'm a strong person that doesn't lack for anything so to sit down in a place and say hey I'm going to talk about how I am right now was kind of like no I was like ... (laughs) (P1, lines 154 – 157) Yeah (laughs) sorry to be like this but I was aware of it (P1, line 159)
Tangible signs to justify ending therapy	Difficulty of travel time and inconvenient venue location Unsettling the safety of her work schedule Impact of therapy on her work routine Colleagues might find out (see through her?) Self as performance	So one of the reasons I guess actually now we are talking about this the whole [name of borough] thing did play a role in my choice to end counselling (P1, lines 202 – 203) The travelling did play a role and then it wasn't just about the travelling it was the fact that basically because it was on a week day in the afternoon and you know it took me you know an hour and a half to go an hour and a half to come back I was losing a whole Friday afternoon I mean I was basically losing a whole working day ... (P1, lines 205 – 208) I guess the specific reasons why I left counselling was more complex than this but

		one of them was that I started leading kind of a dull life because since I was given like basically an entire day of my life to counselling people around me [...] umm all the people around me in my life all this started and saying I was disappearing every Friday (P1, lines 209 – 214)
Remembering and mourning	Beginning to remember – language shifts to anxiety? Denial/repression of assault Inability to be vulnerable; too humiliating; too much like being powerless (the assault) Loss of expected self Needing a tangible measure of progress in therapy – detached from feeling Always thinking of escape, *won't get trapped this time*	... at the beginning it was general generally the beginning like God I have to fucking I have to go there every freaking Friday thinking and talk about stuff like that and you know (P1, lines 327 – 329) ... you get very used to sort of keep it for yourself yeah if that makes sense because you can't you get used to getting sure (P1, lines 332 – 333) ... it's very very hard for me to go to someone and say I'm hurt or like I'm suffering or I'm in pain it's very humiliating for me so in the beginning it was justified that I was generally that uncomfortable but there were the positives where still stronger because I was actually doing better I mean I was doing worse but it was making sense you know what I mean I was doing much worse which meant that I was doing better (P1, lines 335 – 340)

		Yes so I was kind of like as hard as it is it's something I have to do it all the beginning was kind of like as much as I was saying to myself I might just quit (P1, lines 342 – 343)
Something is wrong with therapy/therapist?	Intellectualising Losing a whole work day for something she could do herself? Justification for leaving Doing not feeling – I can heal myself. Flight in to health Something is wrong with therapy/therapist, it is not working Doing not feeling Self-view as practical not contemplative (intellectualising feelings) Language of feelings need to be learned Remembering and mourning feels unsafe Proactive - not feeling Rationalising - not feeling Feelings are unsafe Talking (remembering) is suffocating her	... at one point I felt I didn't need it anymore the process I was going through it was more what I was doing myself than what I was actually doing in the session and going losing a whole day for that (P1, lines 393 – 395) I think that we were incredibly different as people and I was very practical I'm very practical I need to do things I need to have the feeling I'm actually doing something I'm not contemplative and I cannot sit and observe I can't just ... I'm not even sure if it's possible or not but like I need as a person I need to sit down and feel like I'm actually doing something to solve the issue which sometimes not just sometimes like talking about how you feel about things doesn't give me that and as much as I had to learn how to talk about feelings once I started doing it I guess I hoped that we would do something different (P1, lines 399 – 406) once I opened I cried in session like I have never cried in front of anyone after I cried in a session it was really emotional I was like can

	Resisting communicating of feelings (vulnerability) to therapist – fear of powerlessness in relationship Feeling empty as a response to loss that cannot be tolerated Loss of the self	we start doing something in a way and I guess that in the last moment she would have been more positive proactive almost I kind of had the feeling that she was just going to sit there and wait for me to tell her what happened last week or what I didn't do since last week and how that made me feel and part of the session was always the same (P1, lines 406 – 411) ... I guess that in the last moment she would have been more positive proactive almost I kind of had the feeling that she was just going to sit there and wait for me to tell her what happened last week or what I didn't do since last week and how that made me feel and part of the session was always the same (P1, lines 407 – 411) .. but also rationalising (P1, line 414) It's not about I mean I'm not a psychologist so it's really hard to say I mean even just writing down things putting it on the table some physical things to do would have completely changed my attitude you know what I mean (P1, lines 416 – 418) It's just that talking session that sort of feels so suffocating almost (P1, line 420) ... No I didn't feel like I had the knowledge to say anything like that she's the expert not me I

		sit down and say like I'm not a psychologist [...] I absolutely understood why she wanted me to talk and open up and I was fine doing it and I absolutely fine about the fact that I had to go through an emotional journey because I'm not used to it and once I've done it I wished there was something instead of falling into the void (P1, lines 422 – 427)

Appendix 19c

Table of Superordinate Themes and Related Subordinate Themes Across Participants

Superordinate Theme 1: Client commitment		
Subordinate Themes	**Emergent Themes**	**Sample Transcript Extract**
Focus on recovery (Changed to <u>Disclosure</u>) **Unprepared/unexpected difficulty accepting/vocalising reality of the assault** **Re-emergence of PTSD symptoms** **Minimal contextualising of assault in therapy**	Not coping Time period of disclosure important Time period of support-seeking important Getting lost in the health care system Re-emergence of PTSD symptoms Minimal support network Abandoned Weird Alone Intense Frustration Impediments Interruptions Feeling silence Not feeling heard Emotional	Yeah I mean like aside from the fact it was very ... the whole thing was very weird you know it's very weird to go two years after to a place and suddenly sort of start opening Pandora's box a very weird feeling I wouldn't say it was like traumatising I didn't you know leave the place and say I'm going to cry I was just like it was kind of a weird thing (P1, lines 115-118) And I felt quite like [be]cause at that point like I had no sort of apart from obviously family and friends well I didn't really tell my family but my friends like I didn't have any like I felt quite alone [be]cause I didn't really have that like support (P2, lines 67-68) Yeah I think umm I felt that so it was things that happened a very long time ago and it's quite a long and detailed and complicated story so I thought the best thing is just to explain it all give the broad picture of everything that happened and then we can start dealing with it umm and I think I felt quite frustrated in that I was essentially just trying to explain everything but felt that there was lots of umm lots of impediments to that in that umm understandably my counsellor kept asking me how I felt but I kind of wanted to express what had happened so that my counsellor would then have a better understanding of what am I feeling and why and how to deal with that umm which I think I expressed at some point so the story takes a while to explain and the sessions always seemed very short even if just an hour or a bit less umm and so I felt it might take a session or two before we can actually make any progress then

Unsafe space to disclose	Crying Uncontaining	because there were lots of certain interruptions in that I think I felt like I spent the first three or four or more sessions even just giving the basics and then I think by the time I left counselling my counsellor had very little idea of umm all of the things I experienced and wanted to address. (P3, lines 51-63) Err yes I don't it's funny actually I don't think I remember things particularly clearly it was all quite intense but I found it pretty intense and not particularly containing afterwards I was I rang my friend crying in the street which is something I would never do after my assessment ..." (P4, lines 21-23)
<u>Avoidance</u> **Resurfacing of hyperarousal/re-experiencing symptoms** **Unconscious (unprocessed) defense mechanisms** **Terrifying return to early vulnerable / lost self (or ideal self)**	Anticipating anxiety (vigilance) Struggling with vulnerability Struggling with narrative of assault Talking in the third person (distancing as a safety coping mechanism) Re-experiencing Loss of self/expected self Fragile self-esteem Minimising Focus on food (somatising emotional/psychological distress)	For me it's absolutely terrifying I mean it's like it gets to different people have different reactions to it like I never been good at like I mean I'm not it's like you get very used to sort of keep it for yourself yeah if that makes sense because you can't you get used to getting sure (P1, lines 331 – 333) [...] I just I think also by that point because it had gone on for so long and I'd been waiting and waiting and just reliving this again and again and again I got to the point where I was like I just wanna find someone (P2, lines 176-179) "[…] the way that I felt that was having the most umm severe impact on me at the time was through issues with eating which I'd mentioned in my assessment and which I'd made clear and yet we never talked about that or sort of ways that I might deal with that …" (P3, lines 109-112) yeah ... um I it's interesting cos it was so hard to start talking about anything really so I was probably like spluttering around the first

Affect dysregulation adaptations to guard against memory of assault (somatising / dissociating)	Dissociating	few sessions like no I'm not really gonna talk about anything really uncomfortable and like have you focussed on the fact that the my sleeve of my coat is inside out on the hook or whatever you know like so it was probably quite hard to get me to start ... (P4, lines 339-342)
Retraumatisation (Changed to <u>Emotional Regulation and Resilience</u>) **Flight to health (feeling unsafe)** **Not making connections between feelings, thoughts, and behaviours** **Not learning better self-care skills**	Improved confidence I can heal myself Something wrong with therapy not me Not making a therapeutic connection Intellectualising Destabilised/hypervigilance Rationalising Minimising Hopelessness, resignation, unrewarding Just needing a safe space to be heard Not healing Unsafe to express disappointment	So in a sense it's like I never came to a session to counselling and said I'm fine I'm healed and I don't need sessions anymore that you know a process but it wasn't at one point I felt I didn't need it anymore the process I was going through it was more what I was doing myself than what I was actually doing in the session and going losing a whole day for that (P1, lines 392 – 395) [...] if I had therapy a good therapy person two weeks or three weeks after it happened to me I would have been a disaster like I don't think it would been helpful to me at all I think I was like I was like I couldn't even like think straight I could I needed someone to do the therapy for me I think I needed support of some sort I'm not sure what but I don't know if therapy but I don't if I'd refer ... I'm reluctant but I don't know why it's strange I don't really know why I'm reluctant (P2, lines 514-519) [...] I was just overly optimistic about it and sort of thought well it's so convenient so near my work this should be good this should be helpful and sort of was trying to will it to be helpful and attended for so long but I didn't feel like I was making any progress or like it was useful to me in any way (P3, lines 68-71) I did the whole massive like routine shut the ... oh actually [name of city] is way too stressful for me right now actually I'm gonna move to the [name of city] (P4, lines 137-138)

	Unsafe space to begin authentic dialogue around assault	

Superordinate Theme 2: Client expectancy effects		
Subordinate Themes	**Emergent Themes**	**Sample Transcript Extract**
<u>Attunement</u> (Improving the quality of the client's interpersonal relationships and social functioning for reduction of distress) **Not gaining insight** **Not affirming or rewarding**	I can do it myself Polarised – black and white thinking – creates difference and division (she's this I'm that it will never work) Needs tangible measures of progress – no sense of moving towards recovery Doing, not feeling Practical not contemplative Rationalising Not being listened to Analysing Frustrating	I think that we were incredibly different as people and I was very practical I'm very practical I need to do things I need to have the feeling I'm actually doing something I'm not contemplative and I cannot sit and observe I can't just ... I'm not even sure if it's possible or not but like I need as a person I need to sit down and feel like I'm actually doing something to solve the issue which sometimes not just sometimes like talking about how you feel about things doesn't give me that and as much as I had to learn how to talk about feelings once I started doing it I guess I hoped that we would do something different (P1, lines 399-406) [...] I always thought that someone I paid I was always worried and this was before ... this is really early on I was really worried that I would go somewhere and they'd tell me that there's something cos I wanted someone to tell me there was something wrong with me cos I felt like then I could label things and then it was like a thing and I was really worried someone would tell me that there's something wrong with me so then I'd get a really pessimistic view of mine that's what I was really worried about (P2, lines 539-544) Umm I think so I'm very intuitive so I like to [...] I think aswell I'm I'm very thinking as opposed to feeling so I like to analyse and

Not being heard **Unrewarding relationship** **Not making a therapeutic connection**	Ambivalence – both fear of a diagnosis because then there *is* something wrong with me, and wanting a diagnosis to have some control or mastery over her feelings/the assault Self-analysis of character - inflexible sense of one's self Talking in the third person (distancing as a defense) Not the right approach Therapy is counter-intuitive to expectation or outcome Lack of attunement/therapeutic connection	rationalise umm I mean probably too much I am aware of this so I I I think my counsellor was more feeling than me and that is fine and actually I think useful because I think the issue was that I am often too thinking about err important emotional or significant emotional issues and I was sort of hoping that counselling would be a good framework in which to address that it's unfortunate because the way the framework they were using to view the whole issue was so divergent that there was no yeah I think the combination of sand and stone both being different just meant there wasn't any chance ... (P3, lines 366-375) Yeah but I also feel like I I had maybe decided that it was not the right approach for me or something I don't know but I don't think it is I still would definitely say I'd still recommend and I still think it's very useful I just dunno if that relationship was as good as it could have been or was the right one ... yeah does that make sense? (P4, lines 439-442)
<u>Client-perceived therapist effectiveness</u> **No context for moving towards recovery**	Client and therapist are just too different – black and white/difference and divisions Proactive – not adapting therapy to client Not attuned Powerlessness	... once I opened I cried in session like I have never cried in front of anyone after I cried in a session it was really emotional I was like can we start doing something in a way and I guess that in the last moment she would have been more positive proactive almost I kind of had the feeling that she was just going to sit there and wait for me to tell her what happened last week or what I didn't do since last week and how that made me feel and part of the session was always the same (P1, lines 406-411)

No development of a therapeutic frame **No collaboration or working towards goals of therapy**	Passive aggressive Feeling silenced No therapeutic focus No symptom improvement Negative transference/counter-transferences Therapist personality is the problem Therapist's defense Not working through client transferences Not containing Unhelpful Feeling triggered Relationship is not right Unhelpful, ill-timed/re-triggering interpretations	[...] I remember feeling like she was quite different like I think I preferred the person who did my assessment she felt quite I don't know now but I didn't not like her like I would have been happy to have gone back to her I didn't feel any I didn't think she was something like ... I wasn't ... I didn't think she was really special or like sort of thing (P2, lines 173-176) [...] you know this isn't working between us you know communication isn't really working very well and I was trying to be as diplomatic as about it as possible but you know she said to me at some point that essentially she felt that I just thought that she wasn't very bright and not very competent umm (P3, lines 270-273) [...] some of the things that were said I remember getting quite annoyed about umm a feeling that that an idea of it put in my head about alcohol and drugs was the thing like was I I was drugged or you were drugged or that's how I remember it being said like do you think that or it sounds like you were drugged or something like that but it not being my idea and that really annoying me like (P4, lines 175-179)

<u>Disengaging from therapy</u> **Not improving self-esteem, not learning better self-care strategies** **No framework for healing or recovery** **Reclaiming of some power by clients** **Unrewarding/unsafe/unsupportive therapy frame**	No reason to remain for more of the same Not moving towards recovery Feeling lost and confused in therapy Needing tangible evidence of progress – no sense of improvement or healing Rejecting offer of therapy second time around – taking back some power Unconvinced of any benefits if continue – taking back some power Easing out of/away from therapy (flight to safety) Hostile countertransference *Running away* from therapy	The whole truth was that it was kind of a balance thing it was you know I mean I feel like we weren't going anywhere (P1, lines 500-501) I think I was away for three weeks so I don't think it was like huge but they emailed me back and said unfortunately we can't keep the things for you you'll have to go back on the waiting list which ... ... is fine this is in September so then this is September so then I travelled on September and I got back at the end of September and so they'd kind of I think I got emails (P2, lines 133-136) I went to one session and I said I don't think this is working for these reasons [...] so you know if you can tell me you think if I've made progress for these reasons you know reasons I don't understand umm or what the sort of plan is from here then I am not potentially coming back umm I think she said well you know I can think about that and get back to you next session or something something like that so I felt that I wasn't really presented with any reason to come back to complete the sessions so I emailed her afterwards and said that I didn't think it would be useful for me to come back (P3, lines 213-221) Yeah it was that easing out sort of thing yes I think so probably an element of that yeah I think there were a lots things going on at that time [...] but lots of things were going on and it felt like too much but also I fell in love so that was why I eased out of that well yeah at the time I positive about leaving [name of city] (P4, lines 148-152)

Superordinate Theme 3: Client-therapist relationship		
Subordinate Themes	**Emergent Themes**	**Sample Transcript Extract**
<u>Therapist effect on outcome</u> **Not working in the transference** **No development of attunment** **Development of power differential** **Therapy adapted to the therapist** **Therapist's unprocessed countertransference contaminats therapeutic relationship**	Therapist not attuning to client Therapist felt as expert/therapist felt as professional Unsafe space to challenge the therapy approach (deference of therapist) Not adapting the approach to enhance the client's therapy experience – non holistic Power inequality Feeling silenced Feeling rejected by therapist/WS Therapist's personality is challenging (felt sense of therapist's unprocessed hostile countertransference) Palpable tension Rejecting therapist's interpretations Un-worked through interpretations Retriggered by therapist's interpretations	It's not about I mean I'm not a psychologist so it's really hard to say I mean even just writing down things putting it on the table some physical things to do would have completely changed my attitude you know what I mean (P1, lines 416 – 418) I ... I think by that point I was just so like kind of it felt like a bit downtrodden from the whole experience it was actually other people like a friend of mine who was more appalled by it than me like she was like [...] how can they you know she was much more like ... why? (P2, lines 190-193) [...] and I felt that my counsellor and I were just clearly completely opposite and I could see there is conflict areas of our understanding each other (P3, lines 362-364) ... ... there was definitely an atmosphere of hostility at the end (P3, line 456) [...] I felt I was feeling kind of like that somehow I was like retraumatising myself and that was unethical and the whole like the drug thing there choo choo choo were things that like stand out as un I didn't like them it but not that the whole thing was unhelpful (P4, lines 404-407)

	Therapist's defence Therapist's negative countertransference Feeling judged	
<u>Facilitative conditions of therapy</u> Interpersonal emphasis Equality Empathy **No development of trust/attunement/rapport** **No development of clear goals and strategy for therapeutic work** **No sense of contributing/moving towards recovery**	Unsafe/unsupportive therapeutic space to ask questions/open dialogue about therapy Non development of trust in the relationship Feeling rejected by the WS Getting in touch with outrage Feeling triggered by interpretations Un-worked through interpretations and alliance ruptures Feeling lost and confused Unfriendly and hostile frame Lack of rapport Not non-judgemental Feeling judged	[...] it's a big step to trust someone it's a huge step to go in a place and trust that person that you're going to talk about ... that like the idea of questioning like going to a place and question that and you do it actively and you do it in a positive way I don't think I mean I think it's a huge step because you have to question the trust that you had to create without destroying it by turning it into a different direction and that's like that requires a [inaudible] (P1, lines 477-481) [...] like I don't feel like we have it's not really my right to get counselling here that's how I kind of felt I was like it would be amazing if I could and it would help me a lot but it's not I don't have like it's sounds weird like if it was like the NHS I'd be like no this is my right you can't just cut me off kind of thing (P2, lines 218-221) I think it was just for me it was very nebulous I just didn't really have any idea where we were heading or what the aim was or what the goal was (P3, lines 145-146) [...] I'd I think she said to me that it was it was sort of dangerous what I was doing like working in ... you know talking about like sort of retraumatising myself or something umm I can't remember the term like [...] Something like that umm and then I felt like I'm doing something really unethical kind of thing like by continuing to

		work like and obviously it's a lot how I interpreted it what I heard and what she actually said whatever but I ... (P4, lines 287-294)
<u>The therapeutic alliance</u> **No development of bond of trust, care, and respect** **No agreement on the goals of therapy** **No collaboration on the *work* or tasks of the therapy**	Prompting self-doubt in client (undermining) Struggling to make sense of therapist hostility Struggling to make sense of therapist unwillingness to acknowledge ending Client feeling punished for ending therapy Unconscious (and unprocessed) focus on navigating the relationship with the therapist, at the cost of recovery Confusion and anger Therapist's defence, taking the client's leaving personally – hostile countertransference Un-worked through interpretations Being triggered by interpretations Making assumptions about client's emotional regulation and resilience	I guess because it's kind of its such a weird relationship it's not like ... you have this person that you don't know at all that knows a lot about you and you talk with her but you're not like into a ... start believing that you have a relationship with her but then when that breaks because you say you're not going to do therapy anymore the whole spell breaks and you're like this is a stranger again like [...] I was like should I hug her and like she didn't do anything I was kind of waiting for her to give me like ... because I was like she didn't do something like she would not shake my hand or give me her hand or something so that I can say ok I'll shake hands and she didn't and so we had no physical contact at all (P1, lines 559-569) Well I think I was trying to umm separate the feelings that I was having towards the counselling from the feelings that I was having towards the issues I was talking about (P3, lines 234-235) [...] like I started to feel as if the fact that I was working in [name of organisation] and you know was a thing it was somehow it was a thing it was affecting the way things were talked about or the way and then and then near the end it being said like oh I pushed you harder or something and I was like oh I'm not sure I feel like that's appropriate oh like I find it quite hard to talk about things anyway let alone so but I don't know how you know maybe all of that is something I was bringing (P4, lines 328-333)

	Not reviewing/collaborating with the client to guage feelings (making assumptions) Lack of warmth and respect in development of the relationship Unrepaired alliance ruptures Not developing a client transference narrative Not creating space for opportunity to repair ruptures Projective identification – un-worked through therapist defence and unconscious processes Negative therapist countertransference Hostile and frustrating therapeutic framework – lack of goals, tasks and focus of therapy	

Appendix 20

Table 9: Illustrating participant number, pseudonym and quotations used.

PARTICIPANT	PSEUDONYM	QUOTATION
P1	**Mira**	lines 115-118 lines 331-333 lines 392-395 lines 399-406 lines 406-411 lines 500-501 lines 416-418 lines 477-481 lines 559-569
P2	**Hailey**	lines 67-68 lines 176-179 lines 514-519 lines 539-544 lines 173-176 lines 133-136 lines 190-193 lines 218-221
P3	**Alisa**	lines 51-63 lines 109-112 lines 68-71 lines 366-375 lines 270-273 lines 213-221 lines 362-364 line 456 lines 145-146 lines 234-235
P4	**Helen**	lines 21-23 lines 339-342 lines 137-138 lines 439-442 lines 175-179 lines 148-152

		lines 404-407 lines 287-294 lines 328-333