Making sense of complex childhood trauma:

The power of the therapeutic relationship to derail or validate.

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Declarations

Statement of Originality

This thesis contains no material which has been accepted for the award of any other degree or diploma in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text. I give consent to this copy of my thesis, when deposited in the University Library**, being made available for loan and photocopying subject to the conditions of the Copyright Act 1968.

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Acknowledgment of Collaboration and Authorship

I hereby certify that the work embodied in this thesis contains a scholarly work of which I am a joint author. A/P Lynne McCormack solely contributed to the design of the research, and I recruited participants, conducted the semi-structured interviews, and transcribed the data. A/P McCormack was the independent auditor during data analysis and supervised revision of the thesis. I also conducted an independent audit of the transcripts prior to both authors robustly collaborating on final thematic content. I have compiled this thesis as part requirement of a Masters of Clinical Psychology and as such have taken the lead in writing of the initial and final versions of the thesis.

Signed:

Jee Hea Song	A/P Lynne McCormack
Date 14th November, 2018	Date 14th November, 2018

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Abstract

No known research explores the interpersonal dynamics of the therapeutic relationship in adult life following childhood abuse. For adult survivors of childhood trauma the therapeutic relationship has the potential to mimic the dynamics of earlier abusive relationships with caregivers: power, authority, trust, privacy, aloneness and therapist gender. Using Interpretative Phenomenological Analysis (IPA) this study explored the participant's subjective interpretation of the therapeutic relationship as an adult in the aftermath of complex childhood trauma. In doing so, it explored both positive and negative interpretation of the participant's experience of the therapeutic relationship. Data revealed one superordinate theme: *Irony of Judgement*, which overarched 6 subordinate themes: *a)therapeutic relationship, b) being ready for therapy, c) self as compassionate forgiving therapist, d) Intergenerational repeating, e) layers of toxicity, and f) naming the demon inside*. These themes explored layers of toxicity that emerged as participants spoke of destructive trans-generational behaviours that thwarted wellbeing across generations. In recognising intergenerational repeating, engaging in therapy and the therapeutic relationship allowed these participants to separate self and begin an individual journey of recovery. Therapy that was sensitive to adult distress as an aftermath of complex childhood trauma, through a collaborative, non-judgemental person-centred approach, often disallowed the necessity for a diagnosis in adult life. Similarly, where a diagnosis brought meaning to a participant's childhood trauma rather than labelling the adult, recovery was also supported. Therefore, for these participants, therapy had the power to derail recovery through a focus on adult functioning often with invalidating diagnoses, or validate the adult psychological burden from a traumatised childhood not of their own making.

Key words: *Complex childhood trauma; therapeutic dynamics; derailment; validation; hope*.

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Traumatic events, especially those experienced in childhood arising from physical, emotional and/or sexual abuse, can increase the risk of psychopathology and interpersonal problems in adult life (Davis, Petretric-Jackson, & Ting, 2001; McCormack, White & Cuenca, 2016; McCormack & Devine, 2016). Substantial research comparing non-maltreated children with maltreated children, has shown that the latter group displays significantly more problems in regulating emotions effectively throughout childhood (Shipman & Zeman, 2001). In addition, a previous study found that victims of childhood abuse, compared to women who experienced trauma for the first time as adults (e.g. rape, physical assault), have more interpersonal problems at work, and in the home and social domains (Zlotnick, Zakriski, Shea, & Costello, 1996). This is particularly true when victims are harmed by a significant person in their childhood, such as the primary caregiver or attachment figures, whom the child depends upon for survival. Commonly known as betrayal trauma, trust violation by a significant other in childhood is likely to be stored as traumatic amnesia or betrayal blindness in the child's memory (Freyd, 1996).

It is possible that the power dynamics of therapeutic relationships with their inherent 'expert-patient' dynamic could mimic past 'child-parent' power dynamics in cases of childhood trauma. Therapeutic relationship dynamics could mimic past, learned power dynamics, influencing development of the therapeutic relationship. It is important to understand how therapeutic dynamics evolve in this context in order for clinicians to have awareness of, and reflect on, how to empower individuals who are seeking help. There is little previous research exploring this phenomenon. Therefore this study explored the experience of therapeutic relationships and interpretations of the therapeutic space from the perspective of adults who had previously experienced complex childhood traumatic events.

According to Freud (1912/1958, as cited in Diguer et al., 2001), relationship templates consist of schemas or patterns that reflect individual experiences in relationships and past behaviours, which become useful guides in directing future relationships. Likewise, childhood trauma survivors who have been victimized by their trusted caregivers are more likely to display feelings of disconnectedness, isolation and lack of trust in others as adults (Cole & Putnam, 1992). Several studies (e.g. Davis, Petretric-Jackson & Ting, 2001; Ducharme, Koverola & Battle, 1997; Whiffen, Judd & Aube, 1999) examined the interpersonal skills of childhood trauma survivors and found that they experienced difficulties in adjusting to social context and were more likely to engage in dysfunctional intimate relationships, resulting overall in lower quality relationships.

Complex trauma in childhood is defined as "the experience of multiple, chronic and prolonged, developmentally adverse traumatic events, most often of an interpersonal nature, often within the child's caregiving system" (van der Kolk, 2005, p. 2). Consequently, when victims of complex trauma engage in relationships that resemble the abuses of the past, it reinforces the victim's distorted beliefs about self, their worth in relationships, and the motives of others (Pearlman, 2003). Individuals who have been chronically abused and traumatised often seek relationships with others who themselves have trauma or distressing experiences allowing a re-enactment of the unsettling relationship with their primary caregiver or attachment figures from the past (Johnson 2002). Whilst relationships are an important factor in human development, Pearlman and Courtois (2005) argue that relationships such as these, linked to abuse and trauma, set in motion further impairments in interpersonal functioning, mistrust in others, and complicates the need for support and connection.

As explained by Muller, Sicoli and Lemieux (2000), the negative perception of self and self-worth, and the belief that others view them negatively in the context of relationships,

increases the risk of psychopathology. Considering the enmeshment of negativity and fear for survivors of childhood trauma, it comes as no surprise that they are placed at a significantly higher risk for psychopathology as adults. A recent study revealed that victims of direct physical, psychological and sexual abuse by a perpetrator in their childhood recalled shame as the most distressing part of their traumatic experience (McCormack & Thomson, 2017). Additionally, Harvey (2002) proposed that such individuals adjusted their core identity according to their own judgement of their "inner badness" and took on a "false self" to disguise the pain experienced from the treatment of powerful others.

Notwithstanding the evidence for psychopathology in the aftermath of adversity, a range of philosophical and psychological perspectives have proposed the idea of psychological growth as a positive outcome of adverse experiences in childhood (Calhoun & Tedeschi, 1998; Joseph, Williams, & Yule, 1993; Seligman, Steen, Park, & Peterson, 2005). An increasing number of research studies in the field recognise psychological growth as the outcome of positive changes in self, others and life philosophy (Joseph & Linley, 2005; McCormack & Joseph, 2013, 2014; McCormack & McKellar, 2015). Amongst several theories of posttraumatic growth, the organismic valuing process theory of growth (OVP; Joseph & Linley, 2005) explains why some individuals achieve significant personal growth and development in the aftermath of adversity while others do not. It explains the integration of experience of adversity and recovery by combining the theories of growth and trauma proposing that making sense of the trauma narrative through a eudaimonic lens can lead to improvements in personal relationships, self-perception and life philosophy. In summary, Joseph (2011) conceptualizes growth as the acceptance of distressing feelings (such as sadness and fear) that arise from the cognitive struggle to make sense of the reactions to traumatic events, and which can lead individuals to feel much wiser.

Due to disruptions in developmental competencies, survivors are more likely to internalise stereotypes, leading to self-blame and self-loathing (van der Kolk, 2005). Such integral self-judgement can complicate help seeking in survivors of childhood trauma. A recent study by McCormack and Thomson (2017), examined how individuals made meaning of a mental health diagnosis as an adult in the aftermath of complex childhood trauma. This study highlights the double-edged phenomenon of adverse experiences in childhood and the complications of receiving a psychiatric diagnosis in adulthood. Participants in the study disclosed that they sought psychological help to make sense of what was contributing to destructive behaviours and psychological distress in their adult lives, and at the same time were fearful of being stereotyped and judged upon receiving a diagnosis. However, when help seeking provided the 'right' diagnostic fit between distress associated with early abuse and current adult self-perception, adult identity as separate from that of a traumatised child was facilitated. This is supported elsewhere in the literature with individuals being more likely to externalise their adverse experiences and recognise these difficulties as symptoms when a diagnosis validates perceptions and sense of self (McCormack and Joseph, 2013; 2014).

Overall, the accuracy of a diagnosis and reduction in stigma associated with psychological help-seeking can be highly dependent on the therapeutic relationship, which is key to assisting trauma survivors disengage from feelings of unworthiness and self-blame. In addition to giving the 'right' diagnosis, therapists who showed compassion, empathy and validation in their responses empowered the client with increased capacity for psychological growth (McCormack & Thomson, 2017).

Whilst a therapeutic relationship can precipitate personal growth and potentially free individuals from emotional burden, it has the power to be a double-edged sword and violate a client's equity within the relationship. Hardy (1993) identified the main issues that lead to

complications in a therapeutic relationship such as gender, class, ethnic and racial differences, which stimulate the power imbalance between a therapist and a client. The therapeutic relationship can potentially contribute to treatment barriers or conversely minimize distress in adults who have sought psychological help following childhood trauma. As the client begins to disclose personal information in therapy, the power balance shifts in favour of the therapist (Tracey, 1985). In response, clients perceive this power shift as corresponding to the therapist's expertise, position and interpersonal awareness (Douglas, 1985). Crucially, power dynamics in a therapeutic relationship, particularly gender-role conflict can influence psychological maladaptation in psychotherapy (Blazina & Watkins, 1996, 2000).

There is a paucity of research dedicated to the experience of the therapeutic relationship when seeking psychological help as an adult in the aftermath of complex childhood trauma. For adult survivors of childhood trauma, certain aspects of the therapeutic relationship have the potential to mimic the dynamics of power, authority, trust, privacy, aloneness and gender (Pearlman & Courtois, 2005) and potentially contribute to treatment barriers, and minimize distress in adult clients during psychological help-seeking in the aftermath of childhood trauma.

Seeking the idiographic unique insight of the individual into this phenomenon, this study used Interpretative Phenomenological Analysis (IPA; Smith, 1996) to explore positive and negative subjective interpretations of the participants' unique experiences. IPA methodology is informed by the theories of interpretation and phenomenology. This study aimed to explore and reflect on how people make sense of a major experience in their lives that have been rarely explored, rather than attempting to provide specific hypotheses based on predefined categories of experiences (Smith, 2004). Using a double hermeneutic, it sought

to understand how certain aspects of the therapeutic relationship might mimic earlier life relationship dynamics and impact therapeutic progress for these adult survivors.

Method

Participants

All consenting participants, three female and one male, aged between 23 and 47, were recruited through private mental health facilities and local advertisement (Appendix B). IPA samples are selected purposively rather than quantitatively and sample size of three to six participants providing a wealth of data to subjectively explore poorly explored phenomenon (Smith et al., 2009). The selection criteria included: (a) Individuals aged 18 and over; (b) a self-reported history of childhood trauma; (c) received psychological treatment in adulthood; and (d) not currently in crisis. Complex trauma in childhood is defined as “the experience of multiple, chronic and prolonged, developmentally adverse traumatic events, most often of an interpersonal nature, often within the child’s caregiving system” (van der Kolk, 2005, p. 2). Childhood traumatic exposure included domestic violence, emotional abuse, emotional neglect, sexual abuse, physical abuse, death of a parent and witness to extreme interpersonal violence. Types of treatment received both as adults and children included cognitive behavioural therapy, dialectical behaviour therapy, psychoeducation, mindfulness, drug and alcohol treatment and behavioural treatment.

Procedure

Data Collection.

Following university human ethics approval, which can be found in Appendix C, a demographics form, a study information letter, and consent form were distributed to participants (Appendix D). A semi-structured interview was conducted to explore participant’s interpretation of the therapeutic relationship and its potential to trigger relationship dynamics from their traumatic childhood. Time and place of the interviews were

arranged to suit participants. Signed forms were collected at the start of the interview. All interviews were digitally recorded and transcribed under pseudonyms in a password protected device. Each interview took around 60 to 90 minutes. The overall data set was made up of four cases.

Data Analysis.

The auditing and analyses of the data occurs independently and concurrently by each researcher to ensure interrater reliability. Researchers join to discuss each other's findings and come to a final consensus on themes that are unique, rich and supported by the data. According to Smith (1996), the collecting of data and analysis is a steady, repetitive and interactive process that is reliable and valid. In IPA, each researcher listens to digitally recorded interviews, transcribe the interview, provide early notes and interpretations, and look for themes within and across interviews. The convergent (across all interviews) and divergent (within one interview) themes are examined and jointly discussed to arrive at a final consensus between the auditors. The audit trail continues throughout the analysis and write-up of results.

The semi-structured interview used for gathering the data focused on the participant's perception of the phenomena under investigation (see Appendix F for an overview of the analytic steps used in the research).

Validity and Reliability

The terms trustworthiness, credibility and dependability in qualitative research are considered reliability and validity, as measured in nomothetic approach. As proposed by Guba and Lincoln (1981), the rigor in qualitative research is heavily influenced by its criteria of "trustworthiness". Recent researchers have shown that the repeated process of "checking, confirming, making sure, and being certain" establishes validity in qualitative research

(Morse, Barrett, Mayan, Olson, & Spiers, 2008, p.17). As such, the ongoing verification in qualitative research promotes transparency and ensures within-design consistency.

In comparison to quantitative research, the focus is directed towards the subjective interpretations of a phenomenon (Denzin & Lincoln, 2011). In qualitive research, it is not about unravelling the truth or falsity of an observation with respect to an external reality but understanding how people make sense of a phenomenon.

In Interpretative Phenomenological Analysis (IPA), the researcher's empathetic response and perspective taking adds to the rigor of qualitative research (Smith, Flowers, & Larkin, 2009). In IPA, samples are selected purposively rather than quantitatively, data is acquired through a semi-structured interview to encourage participants' meaning making and operates a double hermeneutic to ensure the research is reliable and transparent. The use of double hermeneutics allows the researcher to make sense of the interviewee making sense of their experiences and understand the phenomenon from the perspective of the participant (Smith et al., 2009).

Analytic strategy

Specifically, we were interested in how these participants came to seek help as an adult in the aftermath of childhood trauma, what their expectations were of that help and the positive and negative experiences of seeking therapeutic assistance. Using IPA, we aimed to capture the individual lived experience and the meaning participants brought to those experiences. As an idiographic approach is concerned with a detailed analysis of the data, the interviewer sought to engage the participant as the expert in their life narrative while encouraging them to explore their personal perceptions around events. In addition, the reflective engagement between researchers offered the opportunity for real time engagement in shared reflexivity (Smith, 1996). IPA was used to recognise the relationship between the

individual's perceptions of meaning, and the researcher's attempts at making sense of such perceptions.

Results

An overarching superordinate theme, *Irony of Judgement*, encompasses six subordinate themes: *Therapeutic relationship; Being ready for therapy; Self as compassionate forgiving therapist; Intergenerational repeating; Layers of toxicity; and Naming the demon inside*. For these participants, the overarching narrative of the superordinate theme articulated a journey from the betrayal of childhood trauma as it impacts on the whole of life relationships, to being able to critically engage in a therapeutic relationship with its strengths and weaknesses. Layers of toxicity distorted insight so that behaviours are repeated trans-generationally from adult to child across the generations. Ironically, a blind spot existed that allowed blame to be directed at their own perpetrator yet permitted them to perpetrate against the next generation. For these participants, learning to critically evaluate 'self' nurtured the therapeutic process for changing behaviours. Without the therapeutic relational strengths of being heard, validated and collaboratively engaged with the therapist, diagnosis was seen as extraneous. Only then could recovery become a self-led process.

Therapeutic Relationship

This theme highlights the importance of trust and validation in a therapeutic setting and explores therapist traits that can validate or derail a therapeutic relationship. In general, participants spoke positively of therapy as having led them out of dark places and of continuing to maintain recovery:

> If it weren't for the therapy, I would have been dead… [1] I still see a therapist after all these years, I've got to maintain my recovery and my mental health, my state of mind. (Vincent)

Thrust into unstable relationship patterns as a child, participants struggled to form "healthy" attachments as adults and persistently worried that others might "judge me or label me or stereotype me." There emerged factors such as the severity of the childhood abuse, child's age and relationship between the child and offender, which determined participant's level of adjustment in relationships as adults. Therefore, it was important for these participants when in therapy to build trust and experience empathy with the goal of achieving a positive therapeutic relationship that is professional, compassionate, and understanding:

> I think it is important to have that trust… I was able to trust her [therapist]… I am quite attached to her, but it's not unhealthy attachment… there is a lot of boundaries in place, it is professional, but it doesn't feel very clinical or rigorous, it generally feels like she cares. (Geraldine)

Through a sense of validation and empathy, participants stated that the therapeutic relationship helped restore their experience of detachment from others and opened doors for self-exploration and acceptance in life as adults. Seeking help was a way of rescuing the adult self from the damaged child, build strategies for healthy relational attachment in adult life, and a chance for them to explore and redefine their true values, personality and life goals:

> Things started to turn… I actually became a person with a set personality and I discovered what I am interested in, I actually wanted to stay alive and do things in life. (Caroline)

Participants reported that validation could only occur with the therapist's mirrored congruent behaviour. If the therapist was late to the session or cancelled appointments regularly, these participants felt disenfranchised and began to disengage from the therapeutic relationship:

[1] […] indicates editorial elision where non-relevant material has been omitted.

> But being a therapist… you don't want to be 20 minutes late to every session. You've got to be congruent in your behaviour… and if you're a therapist, you've got to set a good example. (Vincent)

Maintaining genuine and empathetic boundaries was described as the key to forming healthy attachments in therapy. For these participants, therapy resembled a "safe" environment where feelings and beliefs were explored without unwanted pressure. Mutual goal setting and psychoeducation also provided a sense of equality and facilitated disclosure in therapy for these participants. No longer solely concerned with the extremes of their emotions, they discovered a right balance for dealing with their childhood trauma and learning to maintain a positive self-regard:

> I think ultimately finding that balance is positive because you are not disregarding certain sadness or fears or insecurities… it's okay to feel that, it's okay to be sad about it. (Geraldine)

Gender of the therapist played a significant role in eliciting personal growth through therapy for these participants. They reported feeling more open towards therapists with the opposite gender of their childhood perpetrator. The balance of warmth and independence was key within the therapeutic space delivering a sense of protection and freedom that was genuine and created equality for therapeutic progress:

> Female was very important for me because obviously my perpetrators were male… it feels like she is on my level, it doesn't feel like she is exerting power over me at all. (Geraldine)

Being Ready for Therapy

This theme highlights emerging self-awareness and acceptance in these participants despite entrenched fears when faced with distressing memories of childhood trauma. Insightful to the power of intrusion to derail them, participants engaged with a conscious acceptance of painful memories. Metaphorically, they owned their personal scars within therapy with humour and growth:

> I know it will take years just to get to the point of a wound being a scar, and then you've got accept that it's a scar and keep finding a new one every week! (Elizabeth)

By externalising the original source of the problem away from “me” they redefined themselves as survivors of childhood trauma opening doors for self-exploration. However, this reframing led to a powerful transformation for these participants. They now sensed being overwhelmed by the enormity of the trauma and trapped within an historical traumatic narrative that may “shatter” their lives once again:

> It’s really scary to think about how I used to be and how I am now… it just completely wrecked me when I tried to talk about it in depth, I’m scared that it’s going to happen again. (Caroline)

Early attempts at help-seeking was a complex process for them. Participants experienced conflicting emotions as they strive to make sense of the behaviour of their childhood perpetrator whom they also identify as their carer at the time. They were able to articulate how the experience of abuse and neglect had been disguised as a “normal” part of childhood by people they depended on for survival. Such meaningful reflections allowed them to identify their distressing experiences as abuse, yet emphasise the authority of childhood fears to undermine their progress:

> I just thought it was normal… I don’t think I had the ability to recognise what was right from wrong, but I actually see them as abuse now. (Geraldine)

Without external help, without an opportunity to explore the experiences of living in constant fear as a child, they were lucid in recognising how they initially utilised unhelpful coping strategies to suppress the fear of being judged and stigmatised. Fear of replicating the perpetrator’s behaviours grew stronger as they engaged with their past and recognised similar patterns of behaviour in themselves as adults. While still fragile, learning to accept “shame” and making sense of their childhood trauma by seeking professional help facilitated growth and self-exploration for these participants:

> I wanted to be better and I didn’t want to be like them, so there was shame… I used drugs as a coping mechanism, but after learning about the behaviours… then I was able to admit it without that shame. (Geraldine)

Despite benefits from receiving therapy, participants reported that these skills were futile without conscious readiness to seek help. Also, time was a recognised component of healing and participants spoke of experiencing greater gains by allowing their childhood trauma to be processed naturally through the passage of time:

> Even if I run across the perfect person to help me, I need to be ready for help and I don't think I was. I'm still running away from a lot of things… unless I'm ready for it, nothing is going to come out of it. (Elizabeth)

Healing was a gradual and steady progress for these participants. They reported a sense of chronology as slow gains built up with time and layers of experience with therapists and treatment. Nevertheless, their therapeutic experience was seen as enhancing their understanding of one's own emotions and behaviours associated with the childhood trauma, and participants expressed that this brought an overall sense of control and stability in life:

> I was really able to get on with life without extreme fluctuations… over the years I built up trust that I can talk about the thing that comes to my head without the fear that I am like my family. (Geraldine)

Self as Forgiving Therapist

Seeking help as adults, participants mused that talking about their traumatic experiences in therapy facilitated a sense of acceptance and forgiveness towards their childhood perpetrator:

> It helps when you talk about things, if you keep saying it, it eventually stops hurting as much. (Geraldine)

Finding the right words for their complex childhood experiences allowed for self-exploration without the distorted belief that therapy will instantly "fix" them. Recognising their own strength and resilience, participants realised that they can fight through their "darkest times" by practicing being their own therapist:

> It's always going to be my pain… I didn't want to rely on a therapist in my darkest times because they weren't going to be there to face it, I am. (Elizabeth)

The benefits construed by these participants as coming from the experience of forgiving the perpetrator brought further healing opportunities for self and others. Through voluntary work, participants were able to reflect on their personal trauma and achieve self-reparation. They described the experience as “opportunistic” and unplanned, and reflected on a sense that something beyond themselves had organised this pathway for them as part of their own healing process:

> It was opportunistic, it wasn’t something I had planned… I kind of believed that it was all meant to be, kind of like spiritual beliefs. I’ve been put into this role after what had happened to me. (Vincent)

By giving back to the community, hope was fostered and distress became less acute allowing the growthful domains of gratitude, empathy, and wisdom to be brought to consciousness:

> I am a different person. I’ve kind of turned my path into a positive one… what happened to me is my strength… I managed to come through it and turn it all around, now I am going to do something positive with it. (Geraldine)

Invigorated by the positivity that could emerge from distressing “lived experience”, participants sought to give back to the community as a living representation of hope out of adversity. They reported that by giving back they also experienced a sense of self-worth and confidence in life:

> The best thing that can ever happen in this world is someone helping someone else who is in pain… so I try to help as much as I can, this makes me feel worthy. (Elizabeth)

Intergenerational repeating

As the participants ruminated on intergenerational repeating of behaviours, there emerged a realisation that separating out from the family of origin delivers a sense of freedom and the capacity to reflect on their traumatic past and its connection to the present and the future. Within the interviews, participants began to challenge the stigma and shame regarding their role as a victim. This allowed them some adult authenticity separate to that of their family and childhood identities:

> For a long time, it was about hating my family and blaming them for the way things were, but I made a decision, I know now that I can choose how much my past affects my present and my future, and only I can make that decision. (Geraldine)

Recognising forgiveness as the key to freedom, participants discovered that by forgiving their childhood perpetrator they were able to forgive themselves for harmful decisions they have made as adults. Growth out of adversity was facilitated by reparation with self-blame. They spoke of being able to appreciate and be grateful for their lives by continuing to seek help as adults for their childhood trauma:

> Instead of blaming them I am almost grateful for my adversities and what I have been through because it's moulded me into the person I am today. (Geraldine)

Layers of Toxicity

For these participants, complex childhood traumatic events heavily influenced their journey through life and complicated their normal childhood developmental processes. They describe multiple layers of toxicity that emerged as they struggled to separate their childhood experiences and make sense of "self" in adolescence and adult life. Imbedded within this toxicity are invalidating messages from adult carers that undermined their ability to remain subjective and leave them vulnerable to the spurious claims of those around them:

> A lot of adults told me that I was making it up or that I was being overly sensitive about the situation. I constantly had to fight to explain to them that I'm hurting. (Elizabeth)

Distorted and often uncertain beliefs of self were further thrust into an environment of insecurity and disbelief as they tentatively seek help in early adult life. However, instead of offering validation, help-seeking was often experienced as a resumption of the battle 'to be heard' for these participants, and where they were yet again deprived of opportunities to voice their stories and seek help for their childhood "wounds". Participants reported fear and anger associated with the experience of being questioned about their traumatic childhood experiences and facing a therapeutic disbelief in response to their help seeking behaviour:

> She [therapist] just always questioned what I was telling her was true, which really messed with my head… it was really in pieces everywhere and she was like "that doesn't make sense" and she made me question everything that I already was… I felt like I had nowhere else to go to. (Caroline)

For these participants, there was a sense that the caregiving system failed to deliver the right care for them leaving them with an unresolved legacy of chronic and developmentally adverse situations to make sense of. Disheartened by the adult medical model system, they felt that they had no power to deflect or challenge how others judged them:

> I didn't really know how to communicate … I just got so isolated from a lot of people. Nobody wanted to talk to me, I was that weird kid always saying weird stuff and acting weirdly. (Caroline)

This repetition of rejection and invalidation demanded a protective reactivity in these participants as they remembered the need to remain hypervigilant, and expect "pain" regardless of changes in their environment as adults:

> If you have been constantly beaten, yelled at and told horrible things about yourself… you start to react more cautiously because you expect pain. You start to predict it, you think 'this person is going to hurt me'. (Elizabeth)

Participants highlighted the complex interplay of trauma and child development as they reflected on the importance of the parenting role in shaping the child's identity and creating life meaning. For those participants who witnessed or experienced violence, neglect or harmful substance use in childhood discovered repetitive behaviours as adults, reporting similar behavioural problems:

> It was me father, he was an alcoholic… that's how I dealt with it too through my life, I became a substance abuser, alcoholism and that's how I dealt with the trauma. (Vincent)

The repetition was described as a form of escape for these survivors, and as a way of dealing with the horrific childhood events. Ironically however, participants

discovered an added layer of shame and guilt as adults from intergenerational repeating:

> There was a lot of shame and guilt initially, a lot of blame, like it was my fault… the part I played in it was the fact that I abused drugs and alcohol. (Vincent)

Naming the demon inside

Having experienced invalidation of their experiences throughout childhood from adults and other potential carers, a diagnosis without validation, had the potential to further disenfranchise these participants rather than offer a sense of authenticity and distress relief. Therapists, too ready to provide a diagnostic label, often left them feeling "crowded into a box" that was the wrong fit. They spoke of feeling unheard, judged, and being treated with suspicion in a long journey to make sense of their traumatic early lives and the impact on their adolescence and adult lives:

> It didn't fit me … I think a lot of the time they [therapist] were ready to give me a diagnosis without hearing what I was saying. (Elizabeth)

However, there were occasions when although the diagnosis fell short, a label allowed them to name the "demon inside" and provided an explanation for their distressing emotions and behaviours:

> I do believe that labels are helpful … not because it tells me how to fix it, but because it gives a name to the demon inside of you … it gives a name to that thing that is hurting you. (Elizabeth)

Diagnostic labels provided a springboard for these participants to move forward in life and focused on redefining their life goals and values. It also allowed them to redefine their power over their past and how much they will allow past experiences to affect their life in the future. Describing what could be termed as the double-edged sword, participants explained that they felt judged for blaming the perpetrator when they found themselves engaging in similar behavioural problems later in life:

> It turned out that I had become very aggressive in my own way through my drug addiction, so I can't really judge them. If I am judging my father for his alcoholism, well… I am judging myself of substance and alcohol use. (Vincent)

Discussion

This study aimed to explore and reflect on the personal, lived experience of surviving complex childhood trauma. Specifically, the study was interested in how these adult survivors came to seek help, what their expectations were of that help and identify key aspects of the therapeutic relationship that either impacted on their distress positively or negatively. Results indicate one superordinate theme, *Irony of Judgement*, which overarched six subordinate themes: *Therapeutic relationship; Being ready for therapy; Self as compassionate forgiving therapist; Intergenerational repeating; Layers of toxicity; and Naming the demon inside*. Overall, *Irony of Judgement* reflects the interconnection between caretaker betrayal in childhood, developmental disruption, and difficulty in attachment and relationships throughout life. The subordinate themes explored the layers of toxicity where trans-generational behaviours distort insight and a chance for recovery across generations. For these participants, learning to critically evaluate 'self' facilitated a sense of acceptance and forgiveness towards their childhood perpetrator. Diagnosis is seen as extraneous without the therapeutic relational strengths of being heard and validated, which opened doors for self-exploration and acceptance of life as adults. Only then could recovery become a self-led process.

Making sense of the connection between early life trauma and current psychological functioning was complicated by multiple experiences of rejection and cumulative layers of shame and guilt. Schimmenti (2012) suggested that the underlying shame and guilt often prevents trauma victims from seeking help sensing themselves as unworthy of the support. For the participants of this study, initial experience of therapeutic intervention replicated their early neglectful caregiving system and instead of offering validation, they encountered

therapeutic disbelief about their traumatic experiences in childhood. Participants spoke of overwhelming fear and anger towards the medical model system which compounded their help-seeking experience as adults adding another layer of distress and toxicity. As explained by Pearlman (2003), and experience that resembles past relationships as victims of complex trauma reinforces distorted beliefs about 'self' and triggers doubt of worth in relationships.

In comparison to the findings reported by McCormack and Thomson (2017), the most distressing part of seeking psychological help as adults was not about the fear of being judged or stigmatised by others through receiving a mental health diagnosis, but the lack of validation and empathy, and disbelief from therapists. Participants explained that a diagnosis without validation discounted their lasting endeavours to make sense of their traumatic early lives rather than offering a sense of freedom and relief. Complicating this desire for help, participants explained that their purpose for seeking help was not just to be given a label, but to be heard and believed by others.

Overall, the diagnostic label allowed participants to develop an alternative sense of self as an adult that released them from a narrative that perpetuated the risk of transgenerational behaviours of abuse. Ultimately, finding the right therapist with whom they could build a trusting and supportive therapeutic relationship and who provided them with the right diagnostic fit, allowed these participants to move towards more enhanced understanding of self, others and life philosophy (Frazier, Conlon, & Glaser, 2001; Joseph & Linley, 2005; McCormack & Joseph, 2013, 2014; McCormack & McKellar, 2015). Within this study, the therapeutic fit, and the right diagnosis brought release from worthlessness, blame and guilt, and disrupted the cycle of victimisation.

Regardless of powerful transformations with emerging self-awareness and acceptance of painful memories, participants reported overwhelming distress that recollections of their traumatic past may "shatter" their lives once again. Of interest, there emerged factors such as

the child's age, severity of the abuse and relationship between the child and the offender which helped determine adjustment in adult survivors of childhood trauma which is not dissimilar to earlier studies (Faust, Runyon, & Kenny, 1995; Higgins & McCabe, 2000; Runtz & Schallow, 1997). Likewise, these participants spoke of continuing confusion and fears in confronting their emotions in therapy, which has shown to exacerbate feelings of isolation, rejection and distrust of others in relationships (Cole & Putnam, 1992).

Similar to the findings of previous studies, participants reported negative perception of self by engaging in behaviours that were out of character in order to disguise the trauma pain from powerful others (Harvey, 2002; Muller, Sicoli, & Lemieux, 2000). For example, as they reached adult life, attempts at dampening the distress of a traumatic past took the form of anger and resentment towards others mirroring the abusive behaviour of their childhood perpetrators leaving them vulnerable to repeat trans-generational abuse from adult to child across the generations. Paradoxically, there can be a certain status to being a victim blurring the line between victims and abusers. This pendulum of distress, often a defence of a fragile ego, can result in the abused becoming the abuser reaping negative consequences on others (Stosny, 2009).

For these participants, therapy was about seeking the right words for their complex childhood experiences rather than envisaging a quick and easy "fix". Through increased resilience and strength, participants practiced being their own therapist to move towards growth in self, others and relationships. However, without their conscious readiness to seek help, therapy was perceived as futile. Being ready for therapy was recognised as crucial determinant for predicting positive outcome in therapy. In addition, time was recognised as an important component of healing, participants spoke of experiencing greater gains by healing naturally through the passage of time. As stated by Yalom and Lieberman (1991),

posttraumatic growth is often seen as comparable to thriving and resilience, which helps generate a positive psychological outcome following trauma.

Pertinent to this study is the balance of professionalism and warmth in a therapeutic relationship and its potential to bring about change and self-reparative narratives in therapy. As experienced by these participants, the right balance of expert guidance and validation in therapy allows room for personal growth and self-exploration, delivering a sense of protection and freedom to rise above the emotional burden of their childhood trauma. In contrast to the findings of previous research by Tracey (1985), the shift in power balance following disclosure of personal information from participants was not found in the current study (Tracey, 1985). It appeared that the therapist qualities, such as their ability to show compassion, empathy and validation, were more important in shaping the client's view of the therapist's expertise, position and interpersonal awareness. Given the large number of children exposed to physical, emotional and sexual abuse, there is increasing opportunity for therapists to work with victims of complex childhood trauma. Therefore, it is crucial for therapists to be aware of the importance of trust and validation in a therapeutic relationship, and remain sensitive towards gender-role conflict, which can lead to psychological maladaptation in psychotherapy (Blazina & Watkins, 1996, 2000).

These previously unexplored concepts of therapeutic relationship may give understanding to the changes in interpersonal relationships bringing about greater clarity in their expectations of self and others. As reported by participants, therapists who displayed incongruent behaviours by being late to the session or cancelling appointments regularly, seriously jeopardised the working relationship in therapy. It has also been noted that directive approaches in therapy distorted participants pathways to recovery leading to disengagement. Instead, non-directive approaches offering genuine and empathetic boundaries facilitated growth and positive self-regard in therapy (Joseph & Linley, 2006). In addition, participants

described that they felt more comfortable towards therapist with the opposite gender to their childhood perpetrator, which is consistent with the results mentioned from the investigations of Hardy (1993). Previous research suggested that factors such as gender, class, ethnic and racial differences can complicate a therapeutic relationship, creating a power imbalance between a therapist and a client (Tracey, 1985). Accordingly, participants in the current study felt more inclined to share their trauma narratives with therapists who created equality for therapeutic progress by providing psychoeducation and engaging in mutual goal setting.

Limitations

There are several limitations inherent in any qualitative study. The themes described by these four participants in the study are particular to them and cannot be generalised nor can they provide information about cause and effect as in nomothetic studies. Furthermore, as participants are required to reflect on distressing experiences from childhood, there may be biases related to recall and memory. IPA operates a double hermeneutic, the researcher is required to make sense of the participant, who is making sense of their childhood traumatic experience. Therefore, the researcher’s interpretation of the participant’s experience may be shaped by the researcher’s personal life experiences, which may be an inaccurate representation of the participant’s meaning making. In addition, involvement in therapy varied in duration and frequency for each participant. Therefore, future research could consider the effect of type and frequency of psychological treatment on positive change, and the impact of receiving a mental health diagnosis on the therapeutic relationship.

Summary

Childhood is a crucial stage of development for learning self-control, self-concept, expression of different emotions, and the ability to form and maintain relationships with others (Coot et al., 2005; Kinniburgh, Blaustein, Spinazzola, & van der Kolk, 2005). However, childhood trauma complicates normal processes of development in life, leaving

invisible scars (Briere & Jordan, 2009; Cook et al., 2005; van der Kolk, 2005). These narratives were redundant of normal processes of development through the participants exposure to physical, emotional and sexual abuse in childhood. In accordance with attachment theory (Cook et al., 2005), these experiences significantly impacted on these participants view of self, others and the world. However, the participant's subjective interpretation of the therapeutic relationship as adults in the aftermath of complex childhood trauma allowed them to externalise their narratives, and redefine guilt and shame in their role as victims. Some sought other therapists for the right fit between neutrality and trust, and by doing so, began to challenge the stigma and shame experienced as victims. A major step was acknowledged in learning to forgive themselves and by doing so, forgive their childhood perpetrator, facilitating psychological growth as depicted in the themes of *intergenerational repeating, being ready for therapy* and *self as compassionate forgiving therapist.*

The confidence to invigorate positivity encouraged participants to establish effective relationships, built on trust and genuine care. Two even took a step forward to share their "lived experience" and give back to the community through adult careers in child protection or education, with the aim of raising awareness of childhood trauma and working directly with traumatised children and their families:

> I went and worked with traumatised kids with complex needs. That also helped me heal because I was dealing with the little me, I could see myself in them. That was my way of dealing with the trauma. (Vincent)

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Appendix A - Scope of Journal: Traumatology

Traumatology ® is a primary reference for professionals all over the world who study and treat people exposed to highly stressful and traumatic events, such as terrorist bombings, war disasters, fires, accidents, criminal and familial abuse, hostage-taking, hospitalization, major illness, abandonment, and sudden unemployment.

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- post-tsunami training of helpers in Phuket, Thailand 2005
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- vicarious witnessing in European concentration camps: imagining the trauma of
- another
- the counting method: applying the rule of parsimony to the treatment of posttraumatic
- stress disorder
- adaptive coping in adolescent trauma survivors
- emotional release technique: a new desensitization method
- gender differences and acute stress reactions among rescue personnel
- neurological basis for the observed peripheral sensory modulation of emotional

- responses
- post-traumatic stress in youth experiencing illnesses and injuries
- post-traumatic growth and HIV bereavement
- post-traumatic growth following a cancer diagnosis
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Brian E. Bride, PhD, MSW, MPH

Georgia State University School of Social Work

General correspondence may be directed to the Editor's Office.

In addition to addresses and phone numbers, please supply email addresses, as most communications will be by email. Fax numbers, if available, should also be provided for potential use by the editorial office and later by the production office.

Manuscript Preparation

Manuscripts submitted to *Traumatology*® should be prepared in accordance with the Publication Manual of the American Psychological Association, 6th Edition (2010).

Review APA's Checklist for Manuscript Submission before submitting your article.

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Below are additional instructions regarding the preparation of display equations,

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We strongly encourage you to use MathType (third-party software) or Equation Editor 3.0 (built into pre-2007 versions of Word) to construct your equations, rather than the equation support that is built into Word 2007 and Word 2010. Equations composed with the built-in Word 2007/Word 2010 equation support are converted to low-resolution graphics when they enter the production process and must be rekeyed by the typesetter, which may introduce errors.

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If you have an equation that has already been produced using Microsoft Word 2007 or 2010 and you have access to the full version ofMathType 6.5 or later, you can convert this equation to MathType by clicking on MathType Insert Equation. Copy the equation from Microsoft Word and paste it into the MathType box. Verify that your equation is correct, click File, and then click Update. Your equation has now been inserted into your Word file as a MathType Equation.

Use Equation Editor 3.0 or MathType only for equations or for formulas that cannot be produced as Word text using the Times or Symbol font.

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Because altering computer code in any way (e.g., indents, line spacing, line breaks, page breaks) during the typesetting process could alter its meaning, we treat computer code differently from the rest of your article in our production process. To that end, we request separate files for computer code.

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All manuscripts must include an abstract containing a maximum of 250 words typed on a separate page. After the abstract, please supply up to five keywords or brief phrases.

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List references in alphabetical order. Each listed reference should be cited in text, and each text citation should be listed in the References section.

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- **Authored Book:**

Rogers, T. T., & McClelland, J. L. (2004). *Semantic cognition: A parallel distributed processing approach.* Cambridge, MA: MIT Press.

- **Chapter in an Edited Book:**

Gill, M. J., & Sypher, B. D. (2009). Workplace incivility and organizational trust. In P. Lutgen-Sandvik & B. D. Sypher (Eds.), *Destructive organizational communication: Processes, consequences, and constructive ways of organizing* (pp. 53-73). New York, NY: Taylor & Francis.

Figures

Graphics files are welcome if supplied as Tiff or EPS files. Multipanel figures (i.e., figures with parts labeled a, b, c, d, etc.) should be assembled into one file.

The minimum line weight for line art is 0.5 point for optimal printing.

For more information about acceptable resolutions, fonts, sizing, and other figure issues, please see the general guidelines.

When possible, please place symbol legends below the figure instead of to the side.

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The same caption will appear on both the online (color) and print (black and white) versions. To ensure that the figure can be understood in both formats, authors should add alternative wording (e.g., "the red (dark gray) bars represent") as needed.

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Appendix B – Recruitment Flyer

Dr Lynne McCormack
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Ph: 4985 4543

THE UNIVERSITY OF
NEWCASTLE
AUSTRALIA

Volunteers Needed for Trauma Research Study

Making meaning of the therapeutic relationship in Adult Life in the Aftermath of Complex Childhood Trauma

You are invited to take part in a confidential interview for this qualitative study at the University of Newcastle. We are exploring the positive and negative interpretations of the experience of the therapeutic relationship in adult life as a result of those who suffered childhood trauma.

Who is Eligible?

- Individuals aged 18 or over, with a self-reported history of childhood trauma who have sought psychological help in adulthood, and who are not currently in crisis.

What will you be asked to do?

- Take part in a confidential, de-identified audio-recorded interview.
- Complete self-report questionnaires

If you would like more information about participating, please contact:

- Chief Investigator: Dr Lynne McCormack (Senior Lecturer/Clinical Psychologist)
  Email: Lynne.McCormack@newcastle.edu.au or ph: 4985 4543
- Student Researcher: (Judy) Jee Hea Song. Email: JeeHea.Song@uon.edu.au.

This study has approval from the University's Human Research Ethics Committee, Approval No. H-2014-0199

Childhood trauma and therapy Lynne.McCormack@newcastle.edu.au ph: 02 4985 4543 Jeehea.Song@uon.edu.au	Childhood trauma and therapy Lynne.McCormack@newcastle.edu.au ph: 02 4985 4543 Jeehea.Song@uon.edu.au	Childhood trauma and therapy Lynne.McCormack@newcastle.edu.au ph: 02 4985 4543 Jeehea.Song@uon.edu.au	Childhood trauma and therapy Lynne.McCormack@newcastle.edu.au ph: 02 4985 4543 Jeehea.Song@uon.edu.au	Childhood trauma and therapy Lynne.McCormack@newcastle.edu.au ph: 02 4985 4543 Jeehea.Song@uon.edu.au	Childhood trauma and therapy Lynne.McCormack@newcastle.edu.au ph: 02 4985 4543 Jeehea.Song@uon.edu.au	Childhood trauma and therapy Lynne.McCormack@newcastle.edu.au ph: 02 4985 4543 Jeehea.Song@uon.edu.au	Childhood trauma and therapy Lynne.McCormack@newcastle.edu.au ph: 02 4985 4543 Jeehea.Song@uon.edu.au	Childhood trauma and therapy Lynne.McCormack@newcastle.edu.au ph: 02 4985 4543 Jeehea.Song@uon.edu.au	Childhood trauma and therapy Lynne.McCormack@newcastle.edu.au ph: 02 4985 4543 Jeehea.Song@uon.edu.au

Appendix C – Human Ethics Approval

HUMAN RESEARCH ETHICS COMMITTEE

Notification of Expedited Approval

To Chief Investigator or Project Supervisor:	**Doctor Lynne McCormack**
Cc Co-investigators / Research Students:	**Miss Jee Hea Song** **Miss Sherilyn Thomson** **Miss Megan Perry**
Re Protocol:	**Making Meaning of a Psychiatric Diagnosis in Adult Life in the Aftermath of Complex Childhood Trauma**
Date:	**28-May-2017**
Reference No:	**H-2014-0199**

Thank you for your **Response to Conditional Approval (minor amendments)** submission to the Human Research Ethics Committee (HREC) seeking approval in relation to a variation to the above protocol.

Variation to:

1. Add Jee Hea Song (student researcher) to the research team.

2. Remove Cathryn Keeble from the research team.

3. Interview a further 4-6 participants regarding their interpretation of experiencing the therapeutic relationship within the same cohort.

- Information Statement (version submitted 23/05/2017)
- Consent Form (version submitted 23/05/2017)
- Post Interview Consent Form (version submitted 23/05/2017)
- Interview Questions (version submitted 10/04/2017)
- Demographic Questions (version submitted 10/04/2017)
- Impact of Event Scale-Revised, PCL-5 and LEC-5 (submitted 10/04/2017)
- Recruitment Flyer (version submitted 23/05/2017)

Your submission was considered under **Expedited** review by the Ethics Administrator.

I am pleased to advise that the decision on your submission is **Approved** effective **28-May-2017**.

The full Committee will be asked to ratify this decision at its next scheduled meeting. A formal *Certificate of Approval* will be available upon request.

Associate Professor Helen Warren-Forward
Chair, Human Research Ethics Committee

For communications and enquiries:
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Linked University of Newcastle administered funding:

Funding body	Funding project title	First named investigator	Grant Ref

Appendix D – Demographics, Study Information Letter and Consent Forms

Dr Lynne McCormack
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Ph: 4985 4543

Demographics Form For The Research Project:

Meaning making of the therapeutic relationship in adult life in the Aftermath of Childhood Trauma

1. In what year were you born? ……….

2. How would you characterise the type of trauma you were exposed to in childhood?
   - Physical Abuse ☐
   - Emotional Abuse/Psychological Maltreatment ☐
   - Neglect ☐
   - Witness to Domestic Violence ☐
   - Death of a parent ☐
   - Natural or Manmade Disasters ☐
   - Forced Displacement *(i.e. immigrants escaping political persecution)* ☐
   - War/Terrorism/Political Violence ☐
   - Victim/Witness to Extreme Personal/Interpersonal Violence *(i.e., Suicide)* ☐
   - ☐

   Other ……………………………………………………………………………………..

3. How many times have you entered into a therapeutic relationship with a psychiatric/psychological in relation to your childhood trauma?
   ……………………………………………………………………………………
   ……………………………………………………………………………………
   ……………………………………………………………………………………

4. What treatment/s have you received?
   ……………………………………………………………………………………
   ……………………………………………………………………………………

Thank you for taking part in this valuable research.

Dr Lynne McCormack
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University of Newcastle
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Information Statement for the Research Project:

Making Meaning of the Therapeutic Relationship in Adult Life in the Aftermath of Complex Childhood Trauma

You are invited to participate in the research project identified above which is being conducted by Dr Lynne McCormack (Senior Lecturer/Clinical Psychologist) and (Judy) Jee Hea Song (Student Researcher) from the School of Psychology at the University of Newcastle.

Why is the research being done?

The aim of this study is to better understand the positive and negative aspects of the therapeutic relationship in adult life for those who have suffered childhood trauma. For adult survivors of childhood trauma, certain aspects of the therapeutic relationship have the potential to mimic the dynamics of power, authority, trust, privacy, aloneness and gender. Understanding how these or other dynamics impact on the therapeutic relationship can alert therapists to potential treatment barriers and minimise distress for their clients during psychological help-seeking in adulthood as a result of childhood trauma.

Who can participate in the research?

Individuals aged 18 or over, with a self-reported history of childhood trauma who have received treatment in adulthood, and who are not currently in crisis are being asked to participate in this study.

What choice do you have?

Participation in this research is entirely your choice and only those people who give their informed consent will be included in the project. Whether or not you decide to participate, your decision will not disadvantage you in any way. If you decide to participate, you may

withdraw from the project at any time without giving any reason and have the option of withdrawing any of your data.

What would you be asked to do?

If you agree to participate in the study, you will be asked to:

- Read and sign an informed consent form
- Ask any questions you have related to the study
- Provide demographic details
- Fill out brief questionnaires about your general health and well-being before and after the interview
- Participate in an audio recorded interview with the student researcher where you will be asked about the positive and negative aspects of your experience of receiving psychological service.

Because the interviews will reflect your interpretations at the time of the interview, we will not ask you to review or edit the transcript of the interview. However, please be assured that if you wish to withdraw your interview at any time, you are free to do so, and you may have a copy of the audio of the interview if you wish.

How much time will it take?

The interview usually takes around an hour. It may take less or more time, depending on how much you would like to share with the researcher. If you need a break at any time, please feel free to ask.

***What are the risks and benefits of participating*?**

Although it is possible that participants in the interview may feel some increase in stress and anxiety as difficult times are recalled, the interviews are not expected to cause significant distress, particularly as the study is not only interested in negative interpretations, but in positive outcomes and growth also. Any normal feelings of distress will be supported by the student researcher, and participants may also contact the University Psychology Clinic on 4921 5075 or Lifeline on 13 11 14, if additional support is required.

Your story is important and valuable to our understanding of childhood trauma and its consequences. As part of this research, you will have the opportunity to talk about your experiences and tell *your* story. You will also contribute to a more subjective understanding

of what it is like for adults who are seeking psychological help after having experienced childhood trauma.

How will your privacy be protected?

Your data collected from this experiment will be de-identified immediately after collection. All hard data and audio files will be stored in locked filing cabinets or on password protected hard drives within locked rooms, accessible to the research supervisor and student researcher, for the duration of the research and publication of any findings. Furthermore, only those researchers directly involved in this study will have access to these files. The data and consent forms will be disposed of after 10 years or after all investigations are complete.

How will the information collected be used?

The information collected from this research will form a substantial component of the thesis to be submitted by the student researcher. In addition, the data collected may be published in the scientific literature in papers written by the student researcher and the research supervisor. Individual participants will not be identified in any reports arising from the project. Should you wish to receive a copy of any publication please let the interviewer know at the time of interview. If you would like to be contacted in the future for possible follow-up studies please indicate this on the consent form, participation is optional and does not obligate you to participate in future study.

***What do you need to do to participate*?**

Please read this Information Statement and be sure you understand its contents before you consent to participate. If there is anything you do not understand, or you have questions, please contact the student researcher.

If you would like to participate, please contact the student researcher by email. The student researcher will then contact you via phone to arrange a time convenient to you for the interview. The interview will be conducted at a time and place of the participants choosing. You will be asked to sign a Consent Form at the interview.

Further information

If you would like further information about this project please contact (Judy) Jee Hea Song or Dr Lynne McCormack on the contact numbers listed below. Thank you for considering this invitation to be part of this valuable research.

Dr Lynne McCormack
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Complaints about this research

This project has been approved by the University's Human Research Ethics Committee, Approval No. H-2014-0199

Should you have concerns about your rights as a participant in this research, or you have a complaint about the manner in which the research is conducted, it may be given to the researcher, or, if an independent person is preferred, to the Human Research Ethics Officer, Research Services, NIER Precinct, The University of Newcastle, University Drive, Callaghan NSW 2308, Australia, telephone (02) 4921 6333, email Human-Ethics@newcastle.edu.au.

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Consent Form For The Research Project:
Making Meaning of the therapeutic relationships in Adult Life in the Aftermath of Complex Childhood Trauma

I have been invited to participate in the above study, which is being conducted by Dr Lynne McCormack (Senior Lecturer/Clinical Psychologist) and (Judy) Jee Hea Song (Student Researcher/Psychologist) from the School of Psychology at the University of Newcastle. My agreement is based on the understanding that the research study looks at my experience, both positive and negative, of the therapeutic relationship in adult life, due to ongoing responses to childhood trauma.

I consent to: (please TICK each box)

- ☐ I agree to participate in the above research project and give my consent freely.
- ☐ I understand that I can refuse to consent, or withdraw from the study at any time without explanation and this will not affect my relationship with the University of Newcastle.
- ☐ I understand that my personal information will remain confidential to the researchers and all interview data will be de-identified and stored separately.
- ☐ I have received and read the attached 'Participant Information Sheet' and I understand that the project will be conducted as described in the Information Statement, a copy of which I have retained.
- ☐ I consent to attending an interview session as part of this study which will be audio recorded.
- ☐ I understand that I will be asked to complete several questionnaires
- ☐ I consent to de-identified excerpts from the data being used for research purposes, scientific publication, conference presentation and/or for teaching purposes.
- ☐ I understand that I will not be required to proof the transcript but may request an audio copy of my interview.
- ☐ I give permission to be contacted in the future for possible follow-up studies using the following contact details (optional)

- [ ] I have had the opportunity to have all questions answered to my satisfaction.

Participant Name: ……………………….……………………..……………………………..

Participant Signature: ……………….………………………… Date: ………………………..

CONTACT DETAILS:

NAME:

Email address:

Phone Numbers: (m) ***(h)*** ***(w)***

Mailing Address:

Appendix E – Semi-Structured Interview

Example questions include:

1) How do you believe deciding to seek help in adult life for your childhood trauma responses has impacted on your life so far?
2) How do you feel you may have changed as a person because of this help-seeking experience?
3) Has this help seeking impacted on you positively as well as negatively?

   Prompt if necessary: can you tell me about the positive and negative dynamics of relationship?
4) How do you make sense of the human dynamics within therapy that you have experienced?
5) Can you describe psychological/philosophical/existential thoughts that have altered or become part of your thinking in the process of this help-seeking experience?
6) How has seeking help influenced your feelings, thoughts, relationships and goals?
7) How do you feel that your future will be influenced from this experience?

Appendix F – Overview of Analytic Steps

Step 1: Listening, reading and re-reading. The interview was audio recorded and listened to several times before transcribing. Researcher repeatedly read over the transcripts and became familiar with the data before recording an initial impression of data.

Step 2: Initial noting. Researcher examined the language and semantic content of the transcript and identified content that reflects what is most important for the participant. The data was critically analysed using these descriptive notes of the content, meaning and interpretation to understand participant's language and experiences.

Step 3: Developing emergent themes. The themes that emerged during data analysis were recorded on the right-hand column of the transcript in hardcopy. Throughout the transcript there were clear connections and patterns between the initial notes and the emergent themes. The student researcher and supervisor analysed the data independently and then met up to discuss about their own interpretations of the semantic content and language to select the most important aspects of the data.

Step 4: Validity/Credibility. The student researcher's supervisor performed an independent audit of the data at the same time to provide a quality control measure for the student researcher's interpretation of the content and themes, ensuring the validity and credibility of data (Smith, 1996). The potential for researcher biases and presuppositions were identified and critically discussed between the student researcher and supervisor to ensure the emergent themes were supported and evidenced by the data.

Step 5: Search for connections across emergent themes. The emergent themes were mapped out on a whiteboard and grouped into categories of themes. Superordinate themes were appointed from these categories and graphed in a table format.

Step 6: Moving to the next case. Each transcript was treated individually and interpreted on its own terms, which requires steps 1 to 5 repeated for each transcript.

Step 7: Looking for patterns across cases. Transcripts were compared with each other to identify possible patterns and connections between transcripts using the superordinate and emergent themes. Convergent and divergent themes were explored. Additional table was shown to demonstrate these connections and patterns across cases.