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Walden University

College of Social and Behavioral Sciences

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Tracy Hollingworth

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Walden University
2019

Abstract

Female Sexual Abuse Survivors and the Therapeutic Relationship

by

Tracy Hollingworth

MS, Capella University, 2013

BS, University of New Mexico, 2008

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Clinical Psychology

Walden University

December 2020

Abstract

Childhood abuse can impact the survivors' life in many ways. Children learn various skills from their caregivers, such as the tools needed to develop and maintain healthy relationships. When a child is abused by their caregiver, there can be a drastic impact on how the child perceives the world, and the therapeutic relationship is important in the healing process. This interpretative phenomenological analysis (IPA) study explored the lived experiences of therapists who work with adult women who are survivors of childhood sexual abuse to better understand the effects that childhood sexual abuse has on the therapeutic relationship. The theoretical base for the study was attachment theory that was conceptualized within a traumatic framework. Participants were recruited through online media forums and with the use of flyers posted at local counseling offices in the metro area of Albuquerque, New Mexico. Eight therapists who self-identified as meeting the criteria for this study were recruited and interviewed in-person; the data was analyzed by hand. Five themes emerged during the analysis: the enhancing effects of disclosure, seeking to empower clients, the client's emotional distress, negative feelings and loss of self, and ability to maintain boundaries. This study contributes to provide avenues for social change by developing awareness and education resources for therapists to increase their effectiveness of treatment and develop ways in which support can be employed to serve the affected population through education and rapport building. This in turn has the potential of increasing successful treatment outcomes, which allows clients to build better external positive, healthy relationships.

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Chapter 1: Introduction to the Study

Introduction

Childhood sexual abuse can impact many areas of a survivor's life, such as relationships, emotional regulation, aggression, trust, and healthy coping skills (Buckley, 2013). The theory of attachment (Bowlby, 1973) suggests that children seek out safety and security from their primary caregivers; this is how children develop an internal working model of themselves and others. They learn how to trust and build relationships with others; this builds self-confidence and a healthy self-esteem. However, serious adverse experiences, such as childhood sexual abuse, can cause the child to create suspicions about others and the world around them. If those emotions and thoughts are not resolved, then those experiences can manifest in adult relationships (Bowlby, 1973). To date, most the research literature in this area has focused on survivors of childhood abuse and has not accurately addressed the effects of childhood sexual abuse on the therapeutic relationship from the therapist's view. In this research, therefore, I evaluated the therapeutic relationship between the female childhood sexual abuse survivor and the therapist. Results from this research can help develop awareness and education resources for therapists to increase effectiveness of treatment given to adult survivors of childhood sexual abuse.

Background

Attachment plays an integral part in the relationships of both men and women throughout their lives, and as such, there has been substantial research dedicated to uncovering the effects of reported childhood abuse on both attachment and adult

relationships; however, not many researchers have explored how childhood sexual abuse can potentially affect the therapeutic relationship. Researchers have found that insecure attachment formed during childhood because of abuse correlates with an abundance of adult relationship problems, both in intimate and nonintimate relationships (McCarthy & Maughan, 2010). These problems vary from trust issues, verbal and physical aggression, and lack of intimacy (Buckley, 2013; Muller, Thornback, & Bedi, 2012). Panesar (2014) reflected upon and shared her own experiences of becoming a therapist, specializing in survivors of childhood sexual abuse, and how her own experience has assisted her with developing therapeutic relationships with her clients. However, there is a gap in previous research regarding the therapeutic relationship between the female childhood sexual abuse survivor and the therapist.

How people perceive their history is a significant mediator between adverse childhood experiences and the quality of adult relationships. Negative childhood experiences, such as criticism, rejection, and being verbally rejected by being told they are unworthy or not wanted, affects the way those children interpret relationships. This, in turn, has a direct impact on the quality of their adult relationships (Muller et al., 2012). Trauma that is related to abuse tends to provoke feelings of aggression and anxiety in the individuals who experienced childhood abuse (Baljon, 2011); this is a direct result of the child having feelings of fear, anxiety, neediness, confusion, and insecurity at the time the abuse occurred (Muller et al., 2012). These feelings have a tendency of becoming apparent in adult relationships.

Researchers have reported that physical and emotional unresolved childhood

abuse is associated with lifelong struggles with emotional disturbance, including poor affect regulation and difficulties with interpersonal relationships (Riggs, Cusimano, & Benson, 2011). According to Buckley (2013), individuals with a disorganized attachment style tend to have the most impairment in relationships. Adults with disorganized or insecure attachment appear to be more likely to develop posttraumatic stress disorder (PTSD) because of their childhood abuse when compared to adults without insecure attachment (Buckley, 2013). These childhood experiences can manifest as vulnerabilities in interpersonal relationships, and unhealthy patterns can develop. Some of these unhealthy patterns seen by survivors of childhood abuse are jealousy, aggression, vengefulness, and destructive behaviors (Reiff et al., 2012).

The psychological effects of trauma associated with sexual abuse can include an altered self-perception, emotional instability, dissociation, flashbacks, sexual confusion, somatic complaints, hallucinations, poor impulse control, and delusional thinking (Reiff et al., 2012). In more severe cases, there is the potential for increased mental health impairments such as bipolar disorder, antisocial personality disorder, schizoaffective disorder, and depression (Reiff et al., 2012).

Trauma can have a severe overall impact on a person's well-being, not just their mental state but also their physical state and health. It tends to overwhelm internal coping mechanisms and adaptive responses (Reiff et al., 2012). Researchers have found that individuals with childhood abuse are often unable to self-regulate their emotions and feelings, and this has resulted in them having difficulty with maintaining relationships (Reiff, 2012). Individuals who are unable to self-regulate and have self-esteem issues are

more likely to engage in illegal substances and criminal behaviors and are more likely to suffer from suicidal ideation. Understanding attachment in the assessment stage of a treatment program and having a positive attachment can, however, influence posttraumatic stress in survivors of childhood sexual abuse (Murphy, Elklit, Hyland, & Shevlin, 2016).

Researchers have shown the importance of interpersonal relationships and how those relationships can affect symptomology and treatment outcomes (Busuito, Huth-Bocks, & Puro, 2014). Difficulties with trust and functioning in relationships can lead to an increase in physical violence and revictimization. During childhood, children seek safety and security from their caregivers; however, when that trust is compromised through sexual abuse, suspicions about their external world and themselves are developed (Carbone, 2010). While it is important for children to receive therapeutic services as early as possible for trauma related experiences, many do not receive the services they need. Researchers have shown that the type of therapy the survivors received as childhood sexual abuse survivors did not influence the outcome of the therapy itself.

The therapeutic relationship is very important in building trust and rapport and allowing the patient to open up and address their trauma. A good therapeutic relationship provides a context for patients to address emotional and psychological pain and learn ways to not only heal but to develop tools to protect themselves in the future (Watson & Greenberg, 2017). This study addressed adult attachment and the therapeutic relationship to help develop awareness and education resources for therapists to increase effectiveness of treatment given to adult survivors of childhood sexual abuse. This current research

study can help provide avenues for social change and develop ways in which support can be employed to serve the affected population through education and rapport building, which in turn has the potential of increasing successful treatment outcomes that allow clients to build better external positive, healthy relationships.

Problem Statement

Despite the amount of research that has been conducted on childhood sexual abuse and relationships, little is known about how childhood sexual abuse influences the therapeutic relationship if survivors seek psychological help as adults. There were 58,105 cases of child abuse reported in the United States in 2014 (U.S. Department of Health & Human Services, 2015). Sexual abuse is unwanted sexual activity, and, in many cases, the perpetrator is someone the survivor knows (American Psychological Association, 2016); children are vulnerable and, as minors, unable to give consent. As adults, many of these survivors need psychological therapy to come to terms with what happened to them during their childhood (Ehring et al., 2014). When a child is sexually abused, especially by an adult they know and trust, they learn negative attachment (Murphy et al., 2016). However, it is unknown whether this attachment affects the survivors' therapeutic relationship.

Literature on the therapeutic relationship between the therapist and female survivors of childhood sexual abuse is limited (Hovey, Rye, & Stalker, 2013). The literature that does exist shows that childhood abuse is associated with insecure attachment in adult romantic relationships (Riggs & Kaminski, 2010). While the therapeutic relationship is not romantic in nature, there is still an attachment and bond

that is expected to form (Jensen & Kelley, 2016). Other childhood experiences such as childhood adversity and gender-based violence can call into question cultural, family, and religious values, which can also affect the perceived quality of the therapeutic relationship (Caplan & Whittemore, 2013). Individuals who have experienced abuse during childhood tend to experience feelings of fear, neediness, anxiety, and insecurity, which characterize insecure adult attachment styles and relationships (Baljon, 2011; Muller et al., 2012). These types of feelings can potentially have a negative effect on the therapeutic relationship (Muller, 2015). However, this has not yet been examined.

It is important to understand the therapists' experience when working with this population, as the relationship they develop with their clients is crucial to their clients' progress. Furthermore, Hovey et al. (2013) argued that researchers should explore women survivors of childhood sexual abuse and the therapeutic relationship, with an emphasis on the condition that prompted their disclosure of abuse. The current study was designed to provide a better understanding of female childhood sexual abuse survivors and the therapeutic relationship, specifically, how childhood sexual abuse affects the therapeutic relationship.

Purpose of the Study

The purpose of this study was to understand how childhood sexual abuse affects the therapeutic relationship from the point of view of the therapist. In this study, I focused on therapists who treat adult female survivors of childhood sexual abuse in an outpatient setting. For the purpose of this study, survivors of childhood sexual abuse were defined as having been abused for a minimum of 6 months between the ages of 5 and 17

years of age by a parent or guardian living in the home. The study consisted of semistructured interviews. A qualitative methodology, specifically interpretative phenomenological analysis (IPA), was used.

Research Questions

The purpose of this study was to understand how childhood sexual abuse affects the therapeutic relationship from the point of view of psychological therapists. To explore this topic, there were three research questions:

1. What are the lived experiences of therapists working with female sexual abuse survivors in terms of their therapeutic relationship?
2. How do therapists describe their therapeutic relationship with this population?
3. How do therapists experience female childhood sexual abuse survivors as clients?

Theoretical Framework for the Study

The theoretical base for this study was attachment theory (Bowlby, 1982) that was conceptualized within a traumatic framework. Researchers have shown the importance of childhood attachment (Murphy et al., 2016); attachment begins at birth, and various attachment styles are possible. These attachment styles are the affective bonds that are developed between a caregiver and an infant. The main attachment styles are ambivalent/preoccupied attachment, avoidant/dismissing attachment, disorganized/fearful attachment, and secure attachment. Secure attachment is what allows the child to develop a healthy self-esteem and teach the child security and positive healthy affection. Researchers have demonstrated that insecure attachment leads to problematic interpersonal relationships (Reiff et al., 2012).

The traumatic framework is a conceptual framework that focuses on what makes the experience traumatic and what psychological responses are expected following such events. It also looks at why symptoms continue once the traumatic experience is over (Carlson & Dalenberg, 2000). Attachment theory was ideal for this study because it helped explain how interpersonal relationships are developed and maintained. If indeed childhood sexual abuse leads to insecure attachment, then attachment theory would show how that insecure attachment could potentially have a negative impact on the therapeutic relationship.

Nature of the Study

The nature of this study was qualitative; specifically, IPA (Smith, Flowers, & Larkin, 2012). Using qualitative research provided an insight on the major life event of survivors of childhood sexual abuse and their therapeutic relationship. In this research, I used a purposive, homogeneous sampling. Data collection stopped once saturation was reached.

IPA is a qualitative methodology that assists with understanding the participants' lived experiences; it helps us understand what a situation is like for participants within a specific circumstance (Smith et al., 2012). With IPA, participants share their experience and express themselves in their own terms, rather than according to any type of predefined category system. IPA focuses on personal meaning and making sense of a particular context for those people who share a specific experience. IPA was ideal for this study because it allowed for an in-depth exploration of the therapists' lived experiences working with female childhood sexual abuse survivors. The therapists had a shared

specific experience because they work with the same population, which was the focus of this study, namely female childhood sexual abuse survivors.

Definitions of Key Terms

Ambivalent/preoccupied attachment: Individuals with ambivalent/preoccupied attachment patterns have needs met in close relationships with a tendency to be overly dependent on their partner or close others as a means of validation through others' acceptance and approval (Bartholomew, Kwong, & Hart, 2001).

Avoidant/dismissing attachment: Avoidant/dismissing attachment patterns tend to be characterized by inhibition of displays of distress and withdrawal from others, particularly when under stress (Bartholomew et al., 2001).

Childhood abuse: Childhood abuse is defined as events experienced before the age of 18 in which behaviors include being locked in a confined space, being hit with an object, being kicked, having objects thrown at the child, being tied up, and/or being burnt (Reiff et al., 2011).

Disorganized/fearful attachment: Disorganized/fearful attachment patterns are characterized by a child's fear of his or her primary caregiver as a result of abusive behaviors toward them (Main & Hesse, 1992).

Physical abuse: Physical abuse is behavior that can include threats with weapons such as a knife, stabbing, or shooting. Hitting with the hand resulting in bruising or severe pain is considered physical abuse (Reiff et al., 2011).

Secure attachment: Secure attachment is indicative of a high self-esteem and the ability to maintain close intimate connections with others while maintaining a sense of

self and self-worth (Bartholomew & Horowitz, 1991).

Sexual abuse: Sexual abuse during childhood consists of sexual experiences, which can include the child performing or having performed on them, physical contact using various body parts, such as hands and/or feet; giving or receiving oral sex; and/or genital/anal sex occurring before the age of 13, with or without consent (Reiff et al., 2011).

Therapeutic relationship: Therapeutic relationship refers to the relationship between a patient and their healthcare professional. It is the means by which the patient and the therapist hope to engage with each other, which in turn can result in beneficial change in the patient.

Therapy: Therapy refers to treatment that is intended to heal or at least relieve a disorder; it is the treatment of mental or psychological disorders by psychological means.

Assumptions

For this research study, I assumed that the therapeutic relationship is an essential part of therapy, especially when treating female childhood sexual abuse survivors. I assumed that this sample of therapists was willing and able to understand and answer the questions honestly, candidly, and to the best of their personal and professional judgment. I also assumed that the therapists were honest regardless of their therapeutic relationship with their clients and did not portray their relationship to be anything that it was not, due to fear of judgment.

Scope and Delimitations

In this study, I specifically looked at therapists who provided direct therapeutic

services to at least five female childhood sexual abuse survivors. Prior researchers had identified effects of sexual abuse and the survivor's interpersonal relationships, and I sort to look at the therapeutic relationship from the perspective of the therapist. Therefore, the experience of female survivors from their own perspective was outside the scope of this study.

To participate in this study, therapists had to have self-identify as providing direct services to female survivors of childhood sexual abuse. I looked specifically at female childhood sexual abuse survivors and did not include male survivors. I did not focus on any particular type of therapeutic modality and only concentrated on the therapeutic relationship.

Limitations

Limitations addressed the inherent problems given this research design. One of the limitations of this study was that the sample was drawn from individuals residing in one state, New Mexico, in the United States, and, therefore, may not apply to the general population. The population was drawn from a convenience sample of respondents; this limited the results being able to be used in a broader population. In this study, I focused on female childhood sexual abuse survivors and did not include males; because this study was gender specific, the results do not apply to males and how the therapeutic relationship is effected if they are survivors of childhood sexual abuse. I focused on the therapeutic relationship and not on any type of therapeutic modality. Because the focus was not the therapeutic modality, it was not known as to whether the modality effects the therapeutic relationship.

Significance of Study

This study is unique because it addressed the lack of research and knowledge about the lived experience of therapists who treat female childhood sexual abuse survivors (see Parry & Simpson, 2016). Researchers have shown that individuals who have experienced abuse during childhood tend to experience feelings of fear, neediness, anxiety, and insecurity. These issues characterize insecure adult attachment styles and relationships (Baljon, 2011; Muller et al., 2012) and can therefore drastically impact the therapeutic relationship.

Understanding how childhood sexual abuse can potentially affect the therapeutic relationship would allow service providers, such as therapists, to develop programs to support therapists in developing better relationships with these clients. The National Center for Victims of Crime (2012) found that reported childhood sexual abuse is increasing. Potentially, there will be an increase in these people seeking therapy. To this end, results from this study can help develop awareness and education resources for therapists to increase effectiveness of treatment given to adult survivors of childhood sexual abuse.

Through supporting therapists to develop better relationships with their clients, positive social change can result. When therapists can build a rapport with their clients and develop better relationships, there is the potential of increasing successful treatment outcomes and allowing clients to build better external positive, healthy relationships. Hence, clients and their families can have healthier relationships.

Summary

Current literature has not adequately or thoroughly addressed the effects of traumatic experiences such as physical and sexual abuse during childhood on the adult attachment and the therapeutic relationship among female sexual abuse survivors and their therapists. Research based on women has revealed that childhood sexual abuse, childhood violence, and childhood stressors impact relationships in adulthood (Walker et al., 2009). Individuals who have experienced abuse during childhood tend to experience feelings of anxiety, fear, neediness, confusion, and insecurity, which are prevalent in insecure adult attachment and relationships (Baljon, 2011; Muller et al., 2012).

Implications for social change include adequately addressing issues and exploring the therapeutic relationship. This research highlights a topic that has not gotten much attention. Relevant research will allow for necessary support and education for those therapists who provide direct services to female survivors of childhood sexual abuse who struggle with mental health.

Chapter 2 includes a review of relevant and applicable data and research to provide an in-depth discussion of the effects of childhood abuse, attachment styles, and patterns, as a result of early childhood events. A review of how attachment styles are developed is discussed.

Chapter 2: Literature Review

Introduction

The emotional and psychological effects of childhood sexual abuse in adulthood have been the subject of several studies. Most the research has addressed relationships with family members or significant partners, and therefore can only be generalized to external relationships, especially the therapeutic relationship, with great caution. Many of the studies have addressed the importance of positive attachment at an early age between the child and their caregiver. Childhood abuse, specifically childhood sexual abuse, can result in insecure attachment, which can later affect relationships between the childhood sexual abuse survivor and their family members and/or significant partners (Murphy et al., 2016). Walker et al. (2009) found that childhood sexual abuse was one childhood element that contributed to unhealthy dynamics in adult romantic relationships. Maughan (2010) used the Adult Attachment Interview and found that there was a substantial correlation between insecure attachment and negative functioning in adulthood. These studies support the negative influence that childhood sexual abuse can have during adulthood, but they do not consider the impact that the therapeutic relationship can have in adults who have been sexually abused as children. Therefore, the purpose of this interpretative phenomenological study was to understand how childhood sexual abuse affects the therapeutic relationship, from the point of view of psychological therapists.

I begin this chapter with a description of how the literature was surveyed. The next section of this chapter consists of a review of the literature regarding Bowlby's (1973) attachment theory and is followed by a review of studies investigating female

childhood sexual abuse and mental health, the effects of childhood sexual abuse, childhood sexual abuse and relationships dynamics, and the therapeutic relationship. Lastly, I conclude the chapter with a summary of research related to the selected research method. In the literature review, the rational for additional research in childhood sexual abuse, attachment, and the therapeutic relationship of affected female adults is made evident.

Literature Search Strategy

Articles and books relevant to this study were obtained from various Walden University online library databases. The databases searched included Academic Search Premier, Google Scholar, ProQuest Digital Dissertations, PsycARTICLES, PsycEXTRA, PsycINFO, and websites related to mental health and childhood abuse. The literature search included formative texts obtained through various retailers and numerous library searches. The search was made specific to adult females who reported a history of childhood sexual abuse. Key search terms included *attachment, attachment styles, childhood sexual abuse, insecure attachment, interpersonal relationship, romantic relationship, sexual abuse, therapeutic relationship, trauma,* and *unresolved attachment.* The publication dates for the reviewed literature were between 1973 and 2016. The older works were reviewed due to their relevance in establishing the background on the topic of attachment theory. The articles used were selected by relevance and the most current information on the topic.

Theoretical Foundation: Attachment Theory

The theoretical framework being used in this study was based on the attachment

theory proposed by John Bowlby and was conceptualized within a traumatic framework. It was theorized that individuals are biologically predisposed to develop close bonds with others (Bowlby, 1973). According to Bowlby (1977, 1980), attachment refers to an innate motivational system that evolved to maintain proximity between infants and their caregivers to promote the infant's survival in threatening situations. Attachments typically develop by the time the infant is 6 or 7 months in age, and they are formed between the infant and the person that the infant seeks during their moments of distress (Zilberstein & Messer, 2010). Attachment theory explains how an infant will view their caregiver; the infant can view their caregiver as being emotionally available, consistent, and reliable or inconsistent and unreliable, based on their daily interactions.

Different types of attachment can form, dependent on the relationship between the infant and the caregiver; attachments are developed from biologically driven relationships in which there is a need for comfort, protection, and nurturance (Zilberstein & Messer, 2010). When the infant's basic and emotional needs are met, the infant forms secure attachment. Secure attachment provides the infant with a sense of security, and, in turn, relieves the infant of any type of anxiety and discomfort they may be feeling. When the caregiver provides the infant with a sense of security by being consistent and meeting the infant's basic and emotional needs, the caregiver provides the infant the security to explore the world with confidence; this attainment is considered the "safe haven" function of secure attachment (Lee & Montelongo, 2016).

However, when there is a lack of maternal affection or consistency, the infant can develop insecure attachment, known as inconsistent attachment, which in turn can lead to

negative behaviors such as aggressiveness, anxiety, intellectual retardation, and depression in children and later in adulthood (Bowlby, 1973). This happens because the child does not have a secure, reliable base in their caregiver. The child's needs are not being met all the time, and, therefore, they do not learn security and how to deal with their external world. Insecure attachment can also contribute to personality disorders (Crawford et al., 2007). Researchers looked at 239 twin pairs to investigate how attachment styles are related to personality disorders and found that there is a correlation (Crawford et al., 2007).

When a child is abused, a trauma bond can develop; developing a trauma bond can be harmful in forming healthy attachment. Due to trauma bonds being strong, quite often victims of childhood abuse can mistakenly be encouraged to stay in an abusive relationship in the name of attachment even though this can be harmful with respect to healthy attachment (Schwartz, 2015). If the child is abused by their caregiver, they can develop negative or insecure attachment (Murphy et al., 2016) as well as trauma bonds that can be harmful to their adult relationships.

Attachment is formed at an extremely early age, 6 to 7 months of age, and is established by the level and type of interaction that occurs between the infant and their caregiver. The infant forms an attachment bond with their caregiver once the infant can rely on their caregiver for safety and security (Lee & Montelongo, 2016). Ainsworth, Blehar, Waters, and Wall (1978) identified three distinctions in how attachment is manifested: secure, ambivalent, and avoidant. Infants with a secure attachment tend to explore their environment in a confident manner under safe conditions; however, when

they become distressed, they seek out their caregiver in order to be consoled. This allows the infant to build confidence within themselves to be successful later in life, and the caregiver is seen as a reliable source for security and protection.

However, infants who exhibit ambivalent attachment still explore their environment but do so with less assurance. During times of distress, the infant seeks out their caregiver but have a tendency of showing angry resistance. This occurs when the lines between the adult and child become blurred; often the parent wants to be the child's friend rather than a parent.

The infants who exhibit avoidant attachment fail to seek out their caregiver when they appear to be distressed. While parents who form an avoidant attachment with their child may meet their basic needs, they have a hard time with meeting the child's emotional needs.

Main and Hesse (1992) identified a fourth type of attachment, disorganized, which results in the infant not being consistent in how they respond to distress; this appears to be due to having an inconsistent caregiver. Disorganized parenting can occur when the child's need for emotional closeness is not being met. This can be due to the caregiver either not seeing the child's needs or by ignoring those needs. The child then sees the caregiver's behavior as a source of disorientation or terror.

Over time, children develop ideas about themselves and how they view their external world. They are learning right from wrong and what is considered to be normal. It is not until they start attending school that they learn what social norms are; this can be hard for children who were raised in a household that did not follow social norms,

especially if the child has experienced a trauma bond (Schwartz, 2015). This internal working model is a cognitive framework for which the child formulates mental representations for how to better understand the world, self, and others. These internal working models are part of the child's personality and define social interactions; they set the foundation for behaviors and interpretations in future relationships. This internal working model and attachment have a direct impact on self-esteem. Secure attachment results in high self-esteem and a positive perception of the world, while insecure attachment results in low self-esteem and a lack of faith in their external world and others.

Secure attachment can lead to the development of safe and secure adult relationships, while insecure attachment can lead to problems in adult relationships; specifically, childhood abuse is associated with insecure attachment in adult romantic relationships (Riggs & Kaminski, 2010). Children who experience physical, sexual, and emotional abuse tend to develop working models of helplessness and coercive control (Bowlby, 1982), which can impact relationships later in life.

Attachment Theory in Relation to Childhood Abuse

There are many factors that can influence the development of a child, including attachment. Attachment can affect the outcome of a traumatic event, depending on the developmental stage of the child at the time of the event (Muenzenmaier et al., 2010) as well as the relationship the child has to the perpetrator, home environment, and social supports. Positive, secure attachment can influence less posttraumatic stress in survivors of childhood sexual abuse (Murphy, et al., 2016). Posttraumatic stress symptomology

tends to interfere with a person's emotional, cognitive, and social functioning (Courtois & Ford, 2009).

Researchers have looked at the effect of childhood abuse on adult relationships due to their complex trauma (Reiff et al., 2012). In a qualitative study with 30 participants, the researchers found that individuals with childhood abuse were unable to self-regulate their emotions and feelings and many suffered with negative self-esteem, and, therefore, had difficulty with maintaining relationships later in life. Individuals who have experienced abuse during childhood tend to experience feelings of fear, neediness, anxiety, and insecurity, which characterize insecure adult attachment styles and relationships (Baljon, 2011; Muller et al., 2012). Therefore, it appears that childhood trauma can limit an individual's capacity to develop healthy attachments in adulthood.

Attachment Theory in Relation to Adult Attachment

Researchers have reported that adults who were subjected to physical and emotional childhood abuse had trouble with emotional disturbance, which in turn can cause them difficulty with developing close relationships as adults (Riggs et al., 2011). Negative experiences can increase thoughts of negativity of oneself and relationships (Walker et al., 2009). Results from the Adult Attachment Interview (McCarthy & Maughan, 2010) revealed a substantial correlation between insecure attachment and negative functioning in adulthood. The study consisted of 30 high risk female participants, all of whom reported negative parenting in childhood. The findings of the study suggested that negative childhood experiences may adversely influence development and maintenance of close interpersonal relationships during adulthood.

Human beings have an innate need to connect with others and develop relationships. Experiences of childhood abuse can cause the individual to not seek emotional connections with others, this can lead the individual to a sense of loneliness. This in turn, can contribute to low self-esteem and suicidal ideations (Joiner, 2005). Cassedy et al. (2015) looked at attachment theory as a model of doctor-patient interaction and how the theory can be used as a framework for patient-centered care, this could potentially assist patients with establishing connections and getting the assistance they need. Cassedy et al. found that an individuals' attachment style can influence how they manage stressors. The stressors can be interpersonal, medical, or both; and how the individual manages those stressors can have implications for medical outcomes. Attachment style can influence how well the patient gets along with their doctor and how well they communicate with their treatment team. This can have a huge impact on their treatment outcome. Attachment theory can be used to understand a person's internal and external belief system and can be the basis of change.

Literature Review Related to Key Variables

Childhood Sexual Abuse and Its Effects

Childhood sexual abuse can be defined as a sexual experience in which one person dominates and exploits another by means of a sexual act; this act does not always consist of penetration but can refer to the use of hands, oral sex, or genital/anal sex before the age of 13 regardless of whether it occurred with or without consent (Reiff et al., 2012). Childhood sexual abuse does not include consensual exploratory behaviors among peers but does however, include nonconsensual sexual acts that occur between the ages of

13 and 16 years of age. In many cases, when childhood sexual abuse occurs, the perpetrator is usually someone the survivor knows (American Psychological Association, 2016); any sexual act that occurs between family members is considered to be abuse Reiff et al., 2012).

Many survivors of childhood sexual abuse will need some type of psychological therapy to come to terms with what happened to them during their childhood (Ehring et al., 2014). O'Leary and Gould (2009) reported that males who were abused sexually, during childhood, were 10 times more likely to exhibit suicidal behaviors than males that did not report being sexually abused during their childhood. The research was limited to only male participants and did not look at how childhood sexual affected those participants' adult relationships and/or attachment. However, it demonstrated the serious long-term consequences of childhood sexual abuse.

Muller et al. (2012) conducted a study to determine the role of attachment in the relationship between childhood maltreatment and adult psychological symptomology. The majority of the participants were female, at 82%. Attachment was found to be a mediator for psychological, physical, and exposure to family violence childhood abuse. However, when more than one type of abuse occurred at the same time, attachment only mediated between the psychological abuse and symptomology. Unfortunately, the research did not look at childhood sexual abuse and while Muller et al. did find that attachment style was a contributing factor between childhood maltreatment adult psychological symptomology, it would be difficult to generalize those finding to at least the male population with such a small sample. Nevertheless, these findings indicate that

childhood abuse has a significant effect on adult symptomology, through the mediating effect of attachment.

Other studies on adult symptomology found a relationship between sexual and physical abuse and suicide attempts (Andover et al, 2007), and that found that the prevalence of suicidal ideation was higher, depending upon how painful and provocative the form of abuse was, such as violent sexual or physical abuse that resulted in injury (Joiner et al, 2007).

There have been numerous studies that have looked at the outcomes of childhood sexual abuse on adult relationships; however, these studies have only looked at internal relationships within the family unit. These studies have shown how negative attachment can influence past and future relationships. The relationships usually have negative outcomes for various reasons such as trust. Due to the limited research, generalizations can be made to the female population about how childhood sexual abuse can influence their attachment styles and the quality of their adult relationships, however, no such generalizations can be made between internal and external relationships, such as between a therapist and their client. This is also true for the research participants, most of the studies focus on survivors of childhood sexual abuse and not the people that those survivors interact with.

Childhood sexual abuse has been correlated with eating disorders, higher levels of depression, self-blame, repression, guilt, somatic concerns, sexual problems, shame, dissociative patterns, anxiety, denial, and relationship problems (Hall & Hall, 2011). In children, sexual abuse may influence changeable self-concept that may be symptomatic

of interchanging emotions that fluctuate between feeling special and feeling damaged. These children are at a disadvantage when it comes to interpersonal contexts because they develop a distorted understanding of what caring and loving relationships entail.

It has been established that childhood abuse is a precursor and a maintaining factor for adult psychopathology (Jangam, Muralidharan, Tansa, Raj, & Bhowmick, 2015). While there are only a few studies that have investigated the incidence of childhood abuse in women with psychiatric disorders, literature found that emotional abuse and childhood sexual abuse predisposes women to psychiatric disorders (Jangam et al., 2015). Muenzenmaier et al. (2010) also found that survivors of childhood abuse were more at risk for polysubstance use due to the fact that the polysubstance use allowed the survivor to numb the affect and emotional experience of the abuse. One of the two case study participants also reported possessiveness in their relationships such as jealously and vengefulness; the participants also reported somatic complaints such as headaches and irrational fears (Muenzenmaier et al., 2010)

Additional studies found that female survivors of childhood sexual abuse showed a positive association with clinical post-traumatic stress disorder (PTSD) or post-traumatic stress disorder symptomology; this was evident in pregnant women and postpartum women. While there appears to be an increase in PTSD in pregnant and postpartum women that are survivors of childhood sexual abuse, many women that have a history of childhood sexual abuse experience difficulties becoming sexually aroused to begin with (Rellini et al., 2009). The actual physiological sexual arousal was weaker in participates that were survivors of childhood sexual abuse which may be in part of the

changes in cortisol levels (Rellini et al., 2009). Rellini et al. (2009) found that there was a small decrease in cortisol during sexual arousal among childhood sexual abuse survivors..

Trauma has been known to lead to feeling of depression and low self-esteem in female childhood sexual abuse survivors. A woman questions her role in the abuse when she has experienced sexual abuse during childhood. Findings from an ethnically diverse sample of low-income women reported that obese women with a history of childhood sexual abuse reported higher levels of mental health symptoms (Ramirez & Milan, 2016).

Childhood Abuse and Self-Esteem

Childhood abuse can not only impact on internalizing disorders among older adults but also on self-esteem (Sachs-Ericsson et al., 2010). A longitudinal study was conducted over a three-year time period and the participants were measured at two different times. The results showed that childhood abuse more of a negative effect on those individuals that had low self-esteem. When a child is abused, an insecure attachment is formed which can result in low self-esteem and low feelings of self-worth. A child that has formed a secure attachment and healthy bonds will have a high self-esteem. This self-concept can have an impact on adult relationships and how the individual views the world and others.

Negative body judgment has been linked in the development and maintenance of sexual concerns in women that have a history of childhood sexual abuse (Kilimnik &Meston, 2016). According to Kiliminik and Meston (2016), the sexuality of these women is frequently expressed in extremes of approach and avoidant sexual tendencies. These sexual tendencies have been related to the sexual inhibition and sexual excitation

pathways. To look at self-esteem, Kilimnik and Meston (2016) conducted a study with 139 women that reported childhood sexual abuse and 83 non-abused women. While body esteem was significantly related to the sexual inhibition responses of women in spite of childhood sexual abuse history, sexual excitation responses were only significantly related to those women with a childhood sexual abuse history. The study concluded that the females in the study that had a history of childhood sexual abuse had lower body esteem than females that were not abused. There is therefore a link between childhood sexual abuse and a specific element of self-concept.

Choi et al. (2016) conducted a study that looked at the psychological functioning of Korean children who experienced childhood sexual abuse. The study consisted of 92 sexually abused children; the abuse was confirmed by psychological evaluations and medical forensic interviews. The researchers collected additional psychological evaluations from five randomly chosen elementary schools to make up a control group. The children that were sexually abused scored lower on the self-esteem scale than the children in the control group.

In conclusion, research indicates that childhood sexual abuse can impact self-esteem, self-concept and negative body imagining. This can affect various areas of a females’ life, including their confidence which in turn can affect their education and career.

Childhood Sexual Abuse and Relationships

When children live in fear of violence, they learn to mistrust other and develop insecurities, especially when they felt they could not change their situation (Crawford &

Wright; 2007; Muller et al., 2012). Those feelings of mistrust and insecurity tend to manifest in adulthood and affect interpersonal relationships. As a child, failure to obtain consistent support from the caregiver can also result in the child lacking the ability of acquiring social skills (Mikulincer & Shaver, 2012).

According to Reiff et al. (2012) individuals that have experienced childhood abuse have difficulty maintaining healthy adult relationships because they are unable to self-regulate their emotions and feelings. Survivors of childhood abuse have problems with emotional disturbance (Riggs, et al., 2011) and intimacy disturbances such as distrust and fear (Whishman, 2006) thus they can have difficulty with developing and maintaining close relationships. The inability to trust in a relationship can impact the relationship in many ways including how the individual relates to their partner; this can lead to difficulties in other areas of the relationship, including how the individual relates to their partner sexually. This can cause an increase in the probability of physical violence and revictimization, emotional avoidance, and problems with the individual being able to express themselves emotionally and intimately (Whishman, 2006; Wood, 2006). During childhood, children learn security and trust from their caregivers; however, they can also learn negative attachment if they have problematic relationships with their caregivers (Murphy, et al., 2016) and their security and trust is betrayed. This results in trust issues developing in adult relationships because the survivor can internalize and integrate feelings of self-doubt and ideas of being damaged and unlovable (Kapeleris & Paivio, 2011; Paivio & Pascual-Leone, 2010; Whishman, 2006).

Literature found that while females tended to be more prone to disclose trauma

associated with sexual abuse than male counterparts (O'Leary & Barber, 2008), they are still very much reserved in discussing experiences or seeking help regarding childhood sexual abuse. This occurs even when they have suffered from personal difficulties that resulted in externalizing behaviors, a lack of trust, and a fear of losing control (Muenzenmaier et al., 2010; O'Leary & Barber, 2008) and these externalizing behaviors could explain their poor relationships.

Riggs, Cusimano and Benson (2011) studied 155 couples and looked at relationship quality and self-reporting childhood abuse. They found that attachment in childhood, specifically if the participants' memories consisted of emotional abuse, were significantly associated with relationship quality. Childhood abuse and neglect can also contribute to emotional disturbance, feelings of guilt, feelings of shame, isolation, and difficulty developing close relationships (Riggs et al., 2011). When abuse continues, the ongoing trauma can result in the child having difficulty in developing and maintaining healthy attachments and relationships (Muenzenmaier et al., 2010).

Survivors of childhood sexual abuse have reported increased relationship problems and this has been shown to be associated with low marriage satisfaction. Whishman (2006) found that survivors of childhood abuse, including those that were raped and molested, reported decreased marital satisfaction. Research reported that survivors of childhood sexual abuse had more occurrences of marital dissatisfaction than those who had not reported any type of childhood sexual abuse or maltreatment (DiLillo, Lewis, & Di Loreto-Colgan, 2007; Whishman, 2006). Childhood trauma that involved any type of physical or sexual abuse were found to have a higher probability of marital

disruption ad low marital satisfaction in adulthood.

Sigurdardottir et al. (2012) conducted a study to assess the consequences of childhood sexual abuse on the health and well-being of Icelandic men. This study showed how hard it is for survivors of childhood sexual abuse to not only trust others, but also how that trauma can impact their relationship with their partner. The participants in the study disclosed that they found it difficult to trust their partner and at the same time, how difficult it was for them to be themselves; this was due to them trusting someone from their childhood who had betrayed that trust and abused them. Participants from the study also disclosed that they had concerns about disclosing their abuse to their partners and over time this has led to additional tension within the relationship.

Wells (2016) investigated couples in which one of the partners was abused as a child. Wells (2016) introduces the concept of “relational trust” which explains power and dynamics in a relationship, especially as they relate to childhood abuse and the adult-survivor power response. The concept reflects the lack of trust the adult survivor has with their partner in an adult relationship. When a relationship has relational trust both partners have a secure attachment and trust one another. Whereas a relationship without relational trust has an insecure attachment and usually has a negative outcome. This trust issue has a huge effect on all the adult relationships the adult-survivor tries to form and maintain including the therapeutic relationship.

Childhood sexual abuse can affect various aspects of a survivor’s life and their relationships. Since childhood sexual abuse can impact an individual’s mental health and even the physiological health (Busuito et al., 2014) it can consequently have a dramatic

effect of interpersonal relationships (Alaggia & Millington, 2008). Interviews were conducted in one study that explored how childhood sexual abuse affected the current daily lives of men. The study found seven themes that emerged: denial, early sexualization, confusion of their role and responsibility as it related to the abuse, specialness described in the partipants' experiences, ambivalence and sexual disturbance, anger and rage, and loss and hope (Alaggia & Millington, 2008). Many of the participants disclosed substance use and reported experiencing flashbacks of the abuse. Denial was used to block out and repress memories of the abuse as a coping mechanism to deal with what had occurred to them during their childhood. This caused relational problems in their current relationships.

Individuals with complex trauma tend to experience serious difficulties with affect regulation and self-soothing; these difficulties can be damaging in formulating and maintaining adult relationships. When an individual is a survivor of childhood sexual abuse and these feelings, emotions, and unresolved issues connected to this trauma has not been resolved the individual can have a limited capacity for coping, maintaining relationships, low self-esteem, and a negative internal awareness of themselves and others (Muenzenmaier et al., 2010; O'Leary & Gould, 2010; Quina & Brown, 2007; Reiff et al., 2011).

In adult romantic relationships, when the relationship is stable, romantic partners become the primary attachment figures (Buckley, 2013). However, this only occurs when the relationship is stable, which happens when the partner provides the basic needs of a secure attachment. This would consist of support, encouragement to obtain personal

goals, and comfort in times of need. Once these basic needs are met, feelings of security and trust are developed; this leads to the individuals seeking out their partner in times of distress to obtain security (Buckley, 2013) and that feeling of being safe.

Adult attachment styles play a significant role in explaining aggressive behaviors in intimate relationships (Hansen et al., 2011). Research has argued that aggression in interpersonal relationships tends to be more prevalent among ambivalent and avoidant attachment styles (Critchfield, Levy, Clarkin, & Kernberg, 2007). Adult attachment styles appear to be an intervening factor (Muller et al., 2012) with regards to relationship outcomes.

Attachment behaviors can be detected when an adult becomes distressed (Collins & Feeney, 2013). Bartholomew and Horowitz (1991) expanded on Bowlby's (1973) theory of attachment and identified a two-dimensional, four-category model of attachment that explored the potential of adult attachment patterns. The four-category model consists of secure, avoidant, ambivalent, and disorganized. Secure attachment is indicative of positive self-esteem and the ability to make and maintain positive connections with others. Bartholomew's (1999) model of secure partner attachment pattern consists of a positive model of self and others. These individuals have a feeling of self-worth and therefore are comfortable with who they are as a person; this enables them to find pleasure from the closeness of emotional relationships. This type of emotional relationship is indicative of the relationship between a mother and her child, which is considered to be the most important tie during one's lifespan (Malekpour, 2007). Secure attachment is developed when the child's needs are met and the child knows that they are

safe and can trust their caregiver.

Individuals with avoidance attachment patterns typically have problems with nurturance and tend to be competitive, cold, and introverted (Mikulincer & Shaver, 2012). They have a tendency of inhibiting their displays of distress, and typically withdraw from others when they are under stress (Bartholomew et al., 2001). During childhood, these individuals would have had inconsistent attachment figures and when they needed comfort or their basic needs to be met, their needs would be met with rejection. As adults, these individuals suppress their need for closeness from attachment figures due to fear of rejection and as adults the avoidance becomes more of a defensive mechanism. They tend to devalue intimacy and are somewhat detached from their feelings (Buckley, 2013). These individuals are not able to make the connection between their emotions and their negative attachment experiences in childhood.

Ambivalent attachment individuals are concerned with their own attachment needs and getting those needs met through close relationships. They have a negative view of themselves but a positive view of others (Bartholomew, 1999). As children, they were deprived of affection and tended to blame themselves for the lack of love. As adults, individuals with ambivalent attachment patterns tend to overly express themselves in an attempt to maximize their chances of obtaining affection (Bartholomew, 1999). They are usually dependent of their partner as a means to validate their self-worth by others' approval of them. Adults with ambivalent attachment have a higher level of stress and anxiety, with intense negative reactions to external stress, especially when their attachment figures are not responding to their demands (Bartholomew et al., 2001). They

have problems with emotion regulation and can be overly expressive (Milulincer & Shaver, 2012). Individuals with ambivalent attachment patterns have had more reported instances of loneliness and social isolation with low levels of relationship satisfaction, frequent break-ups and frequent incidents of violence and conflict (Mikulincer & Shaver, 2007).

When it comes to relationships, individuals with ambivalent attachment style themes of neediness, insecurity, and fear are common; they tend to fear rejection and abandonment (Muller, 2009). Due to their fear of rejection, they have a tendency of over-exaggerating their distress to fulfill their need for attention. They also fear loss, separation, being alone and too much independence (Buckley, 2013). They have difficulty expressing their emotions and can exhibit some borderline traits. These individuals tend to be obsessive, emotionally unstable, controlling, jealous and possessive (Buckley, 2013) and conflicts in the relationship rise as a means of seeking attention.

Disorganized attachment is indicative of a relationship in which the child is abused by their caregiver and the fear the child has for their caregiver creates disorganization in the attachment structure (van Ijzendoorn & Bakermans-Kranenburg, 2003). Main and Hesse (1992) described this attachment pattern as fright without solution. The caregiver, is perceived by the child to be the source of the stress and not the environment and therefore, the caregiver has now become threatening in the eyes of the child rather than the child’s source of security and trust (van Ijzendoorn & Bakermans-Kranenburg, 2003; Zilberstein & Messer, 2010). Since the child now has to rely on their own coping skills to deal with this internal conflict, their emotion regulation, internal

organization ad relational strategies get hindered (Zilberstein & Messer, 2010).

Individuals with disorganized attachment tend to have mental health disorders such as borderline, dissociative and post-traumatic stress. Unresolved trauma is a critical indicator of unresolved attachment (Wallin, 2007). These individuals struggle with adult relationships (Buckley, 2013) and are unstable in their interactions with their partners (Riggs, 2010). According to Wallin, individuals with disorganized attachment have a tendency to perceive themselves as both the victim and the perpetrator responsible for the trauma.

Childhood Abuse and the Therapeutic Relationship

The therapeutic relationship is an important concept as it relates to the therapeutic process. A good therapeutic relationship provides a context for patients to address psychological and emotional pain and learn ways to not only heal but to also develop tools to protect themselves in the future (Watson & Greenberg, 2017). The therapeutic process is one that allows the patient to heal and the therapist is present and genuine in the process. The therapist is understanding, caring, and attuned to the patient. The therapeutic relationship is an essential part of the process and in part is based on trust.

The therapeutic relationship is very important as it relates to survivors of childhood sexual abuse. Many survivors do not feel that they can trust anyone to share their story with. Furthermore, many of these survivors have developed some sort of mental health disorder and thus seek out treatment. It is believed that many of the therapists that treat survivors of childhood sexual abuse, especially if they have their own history, can be exposed to vicarious traumatization. One study explored the effects of

long term exposure and compared experienced therapists who reported their having their own history of childhood sexual abuse and those that did not. While the study did not find that experienced therapists with a childhood sexual abuse history were more vulnerable to vicarious traumatization, what the study did find was that there were similarities between patients' and therapists' trauma histories which appear to be important factors in evaluating the impact on the work the therapists do with sexual abuse survivors (Benatar, 2000).

Many survivors of childhood sexual abuse have a hard time seeking therapy due to the stigmatization of sexual assault victims. Many survivors feel ashamed, embarrassed, or guilty and will never report the abuse (Simon, Feiring, & Cleland, 2016). Survivors of childhood sexual abuse may internalize the abuse and believe that the abuse was their fault. It may be implied by some professionals and family members that the abuse/rape occurred because of what the victim was wearing, their behavior, or their choice of entertainment (Simon, Feiring, & Cleland, 2016). Society minimizes childhood sexual abuse and it is statistically underreported due to victims not coming forward and making a report. The therapeutic relationship is crucial because it allows the survivor to share their experiences with a neutral person and allows the survivor to put everything into perspective, such as blaming the perpetrator rather than self-blaming (Simon, Feiring, & Cleland, 2016). Many times individuals seek out therapy for other reasons such as eating problems, self-confidence, somatic and alcohol or substance abuse problems not realizing that the underlying reason to many of these issues is their childhood sexual abuse (Lundqvist, Svedin, & Hansson, 2004).

Laughton-Brown (2010) looked at the trust aspect of the therapeutic relationship. There are many components and psychodynamic theories with regards to therapy, such as the clients' characteristics, the therapists' qualities, the change process and even the treatment method. However, the relationship between the client and the therapist is at the center and this is what not only makes for the experience to be successful but some people would also say that it could be considered the vehicle for change.

Parry and Simpson (2016) reviewed 23 qualitative empirical studies that explored how adult survivors of childhood sexual abuse experienced non-specific and trauma-focused talking therapies. Upon review of the 23 qualitative empirical studies, four analytical themes developed: "the therapeutic process as a means for forming connections" (p. 798); "developing a sense of self through the therapeutic process" (p. 800); "therapeutic lights and black holes in the shadows of CSA" (p. 802); and "healing or harrowing: connecting and first time experiences" (p. 804). These themes were found to be important because they all pointed back to relational connections and specifically the importance of the therapeutic relationship. According to the research, childhood sexual abuse survivors need specific relational experiences to move toward recovery.

Therapy and Interpretative Phenomenological Analysis

While many survivors of childhood sexual abuse do seek out mental health services, some do not. In those situations, the survivor does not have that bond and safe place they would have within the therapeutic relationship. Chouliara et al. (2014) conducted qualitative research using IPA to elicit experiences of recovery from CSA in female and male survivors who have/have not utilized mental health services. The

research identified many recurrent themes which all appeared to elicit the need for the therapeutic relationship within the population. The research showed how important the therapeutic relationship was above other aspects of therapy such as the therapeutic approach. The therapeutic relationship allows for disclosure in the healing process which is paramount to recovery. IPA was ideal for this research as it allowed the participants to share their experiences.

Chouliara, et al. (2011) conducted a study in Scotland that aimed to elicit perceptions and experiences of talking therapy for childhood sexual abuse survivors. The study consisted of 13 adult survivors and 31 professionals and used IPA. The researchers identified several themes; however, they separated them into 2 main categories: benefits and challengers. The number one benefit reported by the client was being in a trusting therapeutic relationship.

Another study that used IPA to study childhood was conducted by Walker-Williams, van Eeden, and van der Merwe (2013). The study consisted of 10 female childhood sexual abuse survivors and investigated the coping behaviors and posttraumatic growth of those survivors. There were several themes identified and the researchers categorized them into three major themes: psycho-social spiritual resources; the healing process; and positive strengths. There were limitations with regards to this study that the researchers identified with regards to all the females that participated in the study were all from an urban area and were all educated; therefore, a different population such as females from a rural area or one that is uneducated could potentially provide a different outcome or different themes.

Summary

Research has clearly suggested adverse treatment outcomes for women who have reported a history of childhood sexual abuse. Unresolved childhood sexual abuse tends to manifest in various areas of daily functioning and interactions with others. Childhood sexual abuse impacts interpersonal relationships and in many cases the survivor does not feel safe to share their experience even with their partner.

When children have been subjected to sexual abuse they learn to mistrust others, develop insecurities and form negative attachment. They do not have a positive outlook of their external world and this impacts the way they internalize themselves and others. The mistrust and insecurities that have formed manifest into adulthood and interpersonal relationships. Disorganized attachment prevents the child from learning social skills and positive attachment which then affects the child in adulthood.

The following chapter lays the groundwork for the methodology used in this study in which the therapeutic relationship was explored from the point of view of therapists working with females that have experienced childhood sexual abuse.

Chapter 3: Research Method

Introduction to Methodology

Over the last few years, there has been an increase in childhood sexual abuse (U.S. Department of Health & Human Services, 2015). Due to the increase of cases and severity, these reports have been gaining more attention. It is unclear as to whether these children seek out therapy as either children or adults; it is extremely important for these children to deal with their trauma and build positive, healthy relationships. Researchers have shown the importance of interpersonal relationships and how those relationships can affect symptomology and treatment outcomes (Busuito et al., 2014). Difficulties with trust and functioning in relationships can lead to an increase in physical violence and revictimization. The purpose of this study was to explore the lived experiences of therapists who work with adult women survivors of childhood sexual abuse. To better understand how childhood sexual abuse affects the therapeutic relationship, an IPA was employed as a methodology.

In this chapter, I discuss the methodology of the study. First, I discuss the research design and the rationale, followed by a description of the role of the researcher. Next, I give a description of the study methodology, followed by the issues of trustworthiness and the plan used for addressing them within the study. Lastly, I discuss the ethical considerations pertinent to the study.

Research Design and Rationale

There were three research questions in this study, as follows:

1. What are the lived experiences of therapists working with female sexual

abuse survivors in terms of their therapeutic relationship?

2. How do therapists describe their therapeutic relationship with this population?
3. How do therapists experience female childhood sexual abuse survivors as clients?

Central Phenomenon of the Study

Phenomenology is a philosophical movement founded by Husserl that is used in research to explain and understand the phenomenon of a lived experience thoroughly from a first person point of view (Smith et al., 2009; van Manen, 2014). For the purpose of this study, the phenomenon of *therapeutic relationship* is defined as the relationship between a patient and their healthcare professional (Ardito & Rabellino, 2011). It is the means by which the patient and the therapist hope to engage with each other, which in turn can result in beneficial change in the patient. The objective in phenomenology is to uncover, to understand, to explain, and to thoughtfully interpret the meanings behind the lived experience (Vagle, 2014; van Manen, 2014). The nature of this qualitative study was an IPA in which I attempted to examine how people make sense of life (see Smith et al., 2009).

Research Tradition

In this qualitative study, I used the phenomenological research tradition, specifically IPA. Phenomenological research attempts to recognize, describe, and understand the meaning that individuals attribute to their experiences (Smith et al., 2012). IPA involves a small number of participants; this allows for the shared phenomenon to be

explored more deeply and a comparison to be made to understand any differences and similarities. Smith et al. (2009) articulated that the theoretical foundation for IPA involves hermeneutics and phenomenology. A qualitative phenomenological approach was the best method for this study since I focused on the essence of the lived experience rather than facts (see Moran, 2009). According to Smith et al., phenomenology emphasizes that the human perspective and human experience is necessary in educational research. Similarly, Moran (2009) articulated that phenomenology is "reviving our living contact with reality" (p. 5). Van Manen (2014) expressed that phenomenology is an attempt to explain phenomena as it manifests in the experience and argued that phenomenology rather than a system of methodological procedures is a hermeneutic spiraling practice. In IPA, participants share their experience and express themselves in their own terms, rather than according to any type of predefined category system. IPA focuses on personal significance and making sense of a particular circumstance for people who share a particular experience. This approach allowed for a thorough exploration of the therapists lived experiences working with female childhood sexual abuse survivors.

Rationale

Phenomenology is designed to empirically explain the lived experience through the eyes of those who are actually living the experience. The qualitative research approach typically uses a small sample of participants, rather than a large-scale sample as used in a quantitative research design. The intent is to describe and interpret, rather than generalize, from a sample to the population (Creswell, 2013). This approach provides a

prereflective account of everyday raw experiences, enhancing insightfulness and providing other kinds of understanding (Vagle, 2014). Founding philosophers,Husserl and Heideggar posited that a person should intentionally explore their experiences in order to know more about themselves and that worth is formed from the overlapping or interrelated associations to an experience (as cited in Smith et al., 2009). To understand another person's point of view, it is important to be aware as to how people derive meaning behind the manifestation of their own experiences (Vagle, 2014: van Manen, 2014). Phenomenology is dissimilar to other positivistic research because phenomenology does not consider theory as something that comes prior to practice (Vagle, 2014; van Manen: 2014). In phenomenology, life is seen as occurring first and theory as an outcome of thoughtful interpretation.

Another integral component of IPA involves the reflective interpretation of the lived experience, which is called hermeneutics. Hermeneutics is a theory of interpretation known to be used in the explanation of historical, biblical, and literary texts (Smith et al., 2009). According to Smith et al. (2009), part of the interpretative process focuses on the language the person speaks rather than only the meaning of the words. Interpretation is an interchange of understanding not only the person involved but also the context of the experience. Hermeneutics involves a circulative movement, moving from the whole experience to part of the experience. This is done through a dialogue about the lived experience rather than an account of the essence of the experience (Vagle, 2014). The hermeneutic circle is an iterative dynamic of whole to part and vice versa, which involves a back and forth movement of interpretative analysis throughout the hermeneutic circle.

The meaning can be derived at various levels of subjectivity and/or perception and changes through reflective interpretation (Smith et al., 2009; Vagle, 2014). IPA is intended to explore the lived experience through empirical prereflective description and reflective interpretations.

Other qualitative methods include ethnography, grounded theory, case study, and narrative analysis (Creswell, 2013). However, none of these other qualitative methods were suitable for this study. Ethnography involves an observable social group, which did not fit the intent of this study. My intent of this study was to gain an understanding rather than generate a theory, and, therefore, the grounded theory was not appropriate. Case studies offer an in-depth description of experiences but not to the extent of an IPA. Lastly, a narrative study describes the experience of an individual as it unfolds over time rather than the meaning of the experience. Therefore, an IPA was the most appropriate choice for exploring the lived experiences of therapists working with women survivors of childhood sexual abuse to better understand how childhood sexual abuse affects the therapeutic relationship.

Role of the Researcher

The role of the researcher is primarily to remain in an ethical frame of mind throughout all stages of the research process (Creswell, 2012). As the sole researcher, I was the primary instrument for collecting data, as is the tradition in phenomenological research (see Pietkiewicz & Smith, 2014). Because I was the sole researcher, I was the one conducting the interviews and the one who analyzed the data. The interviews were semistructured, and the tradition of IPA was followed throughout.

Creswell (2013) suggested that the role of the qualitative researcher is to interact with each participant directly. This allows the researcher to obtain a more in-depth understanding of the therapeutic relationship as each participant has experienced it. Due to the interaction, it is important that all personal biases are acknowledged and managed while performing the study to ensure they do not jeopardize the research. Through self-awareness, I do believe that I hold a strong opinion against those who have abused children. This could have had an impact on the data collection and analysis because I could have interjected my personal opinion into the interview and analyzed the results in a bias manner, seeing things that were not there. As a licensed professional clinical counselor, I needed to make sure that I did not interject my own practice onto the therapists that I interviewed. To prevent this, I conducted semistructured interviews based on questions that were already approved for my research. I was mindful of the sensitivity of the subject matter and population when asking the questions and recording the results for later analysis. I also needed to be mindful that childhood sexual abuse is a sensitive subject, and I believed that my personal view held no stigma towards this subject matter. I was able to make sure that the participant being interviewed felt comfortable, and I provided the participant with resources at the end of the interview process so that they could process any feelings that they had as a result of the interview process.

Methodology

Participant Selection Logic

For this study, a homogenous sample was used, as recommended for IPA (see Smith et al., 2012). According to Smith et al. (2012), a homogenous sample consists of

participants who share similar characteristics or traits. In this study, I focused on therapists who self-identified as working with female adult, childhood sexual abuse survivors.

The criteria for participant selection consisted of these factors: (a) Therapists who were licensed according to the New Mexico Therapy and Counseling Board, (b) individuals who have been treating adult female survivors of childhood sexual abuse in an out-patient setting, (c) the individuals who have had at least two adult female survivors of childhood sexual abuse on their current caseload, (d) individuals who have treated at least 10 adult survivors of childhood sexual abuse over their career, and (e) female survivors of childhood sexual abuse needed to have been abused for a minimum of 6 months between the ages of 5 and 17 years of age by a parent or guardian living in the home.

Once identified, participants were interviewed until saturation occurred. Saturation is considered to be reached when the data collected during the interview process begins to reveal the same general patterns (Creswell, 2013). The minimum target sample is six participants with the maximum being twelve.

The population was recruited from the metro area in Albuquerque, New Mexico. An advertisement was placed in numerous outpatient clinics and on social media sites that were specific to licensed therapists; public advertisements were used to eliminate any perceived coercion. When potential participants contacted me, more detailed information regarding the study was sent to them, along with a consent form. Those that met the criteria continued on to the interview process until saturation was achieved; participants

that did not meet the criteria or signed up for the study after saturation was met were notified via email and thanked for their time. Those participants that were selected were emailed a copy of the consent form. The consent form was then signed in front of the researcher and then either handed to the researcher or scanned and emailed. Once the consent form was received, the interview was conducted.

Instrumentation

Data were collected through semi-structured interviews conducted in-person or via Skype. The interviews lasted approximately 60 minutes. After receiving the participants' signatures and reviewing the consent form at the time of the interview with the participants, I used a digital recorder to gain access to the lived experience of each participant. Additionally, I prepared an interview agenda with open-ended questions intended to encourage a pre–reflective description, a sense of autonomy, and personal interpretation (Smith, et al., 2009).

The questions used consisted of open-ended questions and pre-planned prompts that provided the ability to build rapport and flexibility in the interviewing process. The main research question asked was "What are the lived experiences of therapist's working with female sexual abuse survivors in terms of their therapeutic relationship?" this was answered by answering additional questions:

1. How do you experience female childhood sexual abuse survivors as clients?
2. How do you experience your therapeutic relationship with female sexual abuse survivors?
3. How is your therapeutic relationship with these clients similar to that with other

clients?

4. How is your therapeutic relationship with these clients different to that with other clients?
5. How do you build rapport with this population?
6. How is this similar and different to how you build rapport with other clients?
7. What are the challenges when working and building a therapeutic relationship with this population?
8. What are the rewards when working and building a therapeutic relationship with this population?
9. What are the similarities in the therapeutic relationship within this population?
10. How do those assumptions affect the therapeutic relationship?

Content validity was established as each interview question was directly linked to the main research question. The use of semi-structured interviews being used in a flexible manner ensured that the data collection was sufficient to answer the phenomenological research question (Smith et al. 2012). My goal was to be very cognizant with regards to the phenomenological intent of the interview, and listen for the unfolding of the essence of the descriptive lived moment. To capture the essence of a lived experience, each participant had the opportunity to voice their stories in relation to the central phenomenon of the therapeutic relationship (Smith, et al., 2009).

Procedures for Recruitment, Participation, and Data Collection

As the researcher, I collected the data through semi-structured interviews in-person. The interviews lasted approximately one hour. Once the interview was complete,

participants were debriefed. The debrief consisted of an explanation of the intent of the study again, which provided the participants the opportunity to ask any additional questions they may have had about the study. After each interview, the digital recording was uploaded to a password-protected personal computer and then saved to a flash drive. All documentation, including handwritten notes and the flash drive are stored inside a lock box in my home. Each audio recording was transcribed by myself. Once each interview was transcribed, a summary of the interview was electronically sent to each participant to review for plausibility and validity through a qualitative process called member checks. Member checking is a process that involves asking one or more of the participants to check their data for plausibility and accuracy (Creswell, 2012). This process also allowed for the participants to clarify any information and responses of the interview.

Data Analysis Plan

To gain insight to the essence of the lived experiences of therapists, data was analyzed through an iterative reflective hermeneutic process. The hermeneutic process allowed for me to shift back and forth throughout the data on various occurrences (Smith, et al., 2009). Understanding was achieved through guided existential inquiry (Vagle, 2014; van Manen, 2014). The process of guided existential inquiry engages universal themes which are often connected with human experiences. The overarching themes of temporality (lived time), relationality (self and others), spatiality (space), corporeality (embodiment), and materiality (things) guided my inquiry and analysis.

The first step was to listen to the interviews and read the audio-recorded

transcripts holistically, to reach an understanding from different entry points. Participants' lived accounts remained the focus of my analysis. Smith et al. (2009) stress that one important element with IPA is the movement between the whole and the part, which is circular; this known as a hermeneutic (interpretative) cycle. The hermeneutic cycle provides a new understanding of a whole reality which is developed by exploring the detail of existence. To some degree the lived experiences of the participants in terms of the central phenomenon of the therapeutic relationship depended on a subjective analysis, and allowed me to enter the participants' world through the guided existential inquiry and phenomenological thematic analysis (Smith, et al., 2009: Vagle, 2014).

The next step included the hermeneutic spiral; the hermeneutic spiral process allowed me to move from reading the entire text, to selecting parts of the text and reading line-by-line (Smith et al., 2009; Vagle, 2014). According to Smith et al. (2009), the researcher will write meticulous and all-inclusive notes or comments about the data through close analysis. Close analysis allowed me to form a deeper understanding of the content, such as things that had meaning to the participant and noticing the things that matter, combined with any noteworthy contradictions, differences, or similarities (Creswell, 2012; Smith et al., 2009). Phenomenological data was analyzed using the hermeneutic spiral through an existential method of guided inquiry. Phenomenological analysis can only be used on the pre-reflective experiential data and cannot be used on the beliefs or perceptions of the participants alone (van Manen: 2014). To gain more insight on the lived experience, I looked for connections between the identified themes (van Manen, 2014). According to Smith et al. (2009), thematizing or coding entails

compiling the data or lived experiences into themes to better understand the text. The three types of semantic codes or comments include conceptual (potential meaning nonspecific language), linguistic (potential meaning of specific language), and descriptive (explicit) codes (Smith, et al., 2009). The last step in the analysis process was to identify emergent themes and connections that arose across the themes for all individual participants. This allowed the researcher to discover patterns that applied to all the participants. The iterative nature of IPA permits for flexibility and reflexivity within each individual case and amongst all cases (Smith et al., 2009).

Issues of Trustworthiness

In qualitative research, trustworthiness is essential. To develop trustworthiness, researchers need to demonstrate credibility, dependability, transferability, and confirmability (Lincoln & Guba, 1985). This study accounted for trustworthiness through the means of member-checking, reflexive journaling, audit trail and triangulation. To establish levels of dependability, reflexivity, and creditability throughout the research, this study was conducted using Lincoln and Guba's (1985 – I think) guidelines for qualitative research.

Credibility

To ensure trustworthiness, I showed credibility, dependability, and confirmability. Credibility refers to the capacity of belief of the research and the quality or power of inspiring belief.

Prolonged engagement. Prolonged engagement refers to investing sufficient time to learn about the population. This includes gaining trust, and testing for any biases either

from the researcher or the participants (Lincoln & Guba, 1985). I spent time prior to the start of the interview with the participants to build rapport.

Reflexive journaling. Reflexive journaling was used throughout the research process to assist in managing any researcher biases. It also served to notate any impressions in regards to the interviews and monitoring any developing constructions.

Triangulation. Triangulation refers to the use of two or more sources (Carter, Bryant-Lukosius, DiCenso, Blythe, & Neville, 2014). Triangulation adds credibility by ensuring that the account is rich, robust, comprehensive, and well-developed. This study used a homogenous sample which was made up of several participants, thereby creating triangulation.

Member-checking. The participants were emailed summaries of their interviews so that they were able to check and clarify any information with regards to their interview.

Transferability

Transferability refers to a way of achieving a type of external validity. This study does not attempt to make any broad claims but rather make connections between elements of a study and the therapists' own experiences (Shenton, 2004). However, this study describes the phenomenon in sufficient detail so that the study can be transferable to other times, people, and settings; this was achieved using thick description.

Dependability

According to Houghton, Casey, Shaw and Murphy (2013) dependability refers to the stability of the data and inquiry process. Dependability is met when the researcher is able to demonstrate that there were no mistakes and the researcher was careful when

collecting the data, interpreting the findings and reporting the results (Houghton et al., 2013).

Audit trail. The audit trail outlines a transparent description of the steps used throughout the research process (Houghton et al., 2013). An audit trail of the tape recordings, transcripts, reflexive journal, and the data used allowing my dissertation committee to review the raw data and others to understand the analysis process.

Confirmability

Confirmability means the data and interpretations are accurate and true. This study kept good accurate records such as through reflexive journaling and an audit trail that can provide information so that the data can be traced back to the original source (Mertens, 2014). The audit trail contains the complete raw data generated throughout the study, which allows others to verify the trustworthiness of the findings (Lincoln & Guba, 1985). I kept all the records throughout the research process; this allowed me to crosscheck the data and write the final report of the study. Reflective journaling was also used in confirming the data and interpretations for accuracy and making sure that the data did not show any type of bias.

Ethical Procedures

Once the Institutional Review Board at Walden University granted permission (02-19-18-0450787), I recruited participants through an advertisement placed in outpatient clinics in the metro area of Albuquerque, New Mexico and on social media websites that were accessed by outpatient therapists. This study was designed to minimize risk to participants. There was no pressure to read or respond to the

advertisement request, and I had no relationship of any kind with any of the participants. The people who respond were screened to make sure that they met the criteria for the study; those qualified were asked to sign a consent form. All the participants' personal information obtained has been kept confidential. This included any identifying information, such as the names of any therapists, patients, or agencies. At the time that the participant signed the consent form, they each were provided an identification number which was used in all future correspondence to help ensure anonymity and privacy. All information was kept strictly confidential; however, participants were notified of the limits of confidentiality. New Mexico has mandated reporting laws that include reporting child abuse and/or neglect.

The participants selected for this study signed a consent form (Appendix A) that included the purpose, procedures, confidentiality, withdrawal opportunity, and contact information. The participants were given the opportunity to withdraw from the study; they were able to withdraw halfway through the interview, but once I left the room, withdrawing was no longer an option. Interview recordings and personal documents are stored in a locked box and password protected computer. Once personal documents and transcriptions of the interviews were completed and checked for plausibility from the participants, the documents will remain stored on a password-protected computer. The data collected will remain stored a maximum of five years as required by Walden University and at which time will be deleted by shredding the documentation and audio recordings.

Summary

The purpose of this phenomenological qualitative study was to gather descriptive evidence of the lived experiences of therapists that work with female survivors of childhood sexual abuse to explore the affects that the childhood sexual abuse has on the therapeutic relationship. An IPA was used to exploit the pre-reflective descriptions of the individual participants lived therapeutic experience and to construct a reflective interpretation of the lived experience regarding the therapeutic relationship. Eight therapists that have been treating survivors of childhood sexual abuse in an outpatient setting in the Albuquerque Metro area, in New Mexico participated in the study. The data was gathered through semi-structured interviews and handwritten notes which was analyzed using an iterative hermeneutic process of guided existential inquiry (Smith et al., 2009; van Manen, 2014). To establish trustworthiness and credibility, Yardley’s four guidelines included sensitivity to commitment to rigor, context, impact and importance, and transparency and coherence was followed. The intent of this research was to gather descriptions of the lived therapeutic experiences by outpatient therapist treating survivors of childhood sexual abuse in terms of how the childhood sexual abuse affects the therapeutic relationship.

Chapter 4: Results

Introduction

The purpose of this interpretative phenomenological study was to gain an in-depth understanding of the experiences of therapists who work with adult women who are survivors of childhood sexual abuse to better understand the effects that childhood sexual abuse has on the therapeutic relationship. The study's purpose derived meaning from the experiences of eight therapists who work with female CSA survivors in the Albuquerque Metro area of New Mexico. The intent was to capture the lived experiences of therapists working with female childhood sexual abuse survivors in order to develop a meaningful understanding of how childhood sexual abuse affects the therapeutic relationship.

In this chapter, I discuss the current study, including the setting of where the study took place, the demographics of the participants, and the data collection process. Lastly, I discuss the data analysis process and the results of the study.

Setting

The interviews took place in-person with me. Four of the interviews were conducted at the therapists' place of employment, and the other four interviews were conducted in public places (a park, outside a library, and a coffee shop) away from other people. No interruptions occurred during the interviews. There were no incentives given for participation in the research, and the research did not take place in any type of environment where I previously had an active role. There were no known conditions present that I was aware of that may have influenced participants regarding their experience during the interviews that could have had an impact on the interpretation of

the study results.

Demographics

The research sample consisted of eight (*N* = 8) participants who self-identified as being a therapist licensed according to the New Mexico Therapy and Counseling Board, having treated adult female survivors of childhood sexual abuse in an out-patient setting, having treated two adult female survivors of childhood sexual abuse within the last year, having treated at least 10 adult female survivors of childhood sexual abuse throughout their career, having female survivors on their caseload who were abused for a minimum of 6 months between the ages of 5 and 17 years of age by a parent or guardian living in the home, and being fluent enough in English to be able to participant in the interview process. Specific demographic information regarding the participants' ages, ethnicity, and number of years working as a therapist were not asked at the time of the interview as it was not relevant to the research.

Data Collection

Semistructured interviews comprised the method of data collection in this study. A purposive, snowball sampling strategy, including advertisements placed in numerous outpatient clinics and on social media sites was used to recruit participants. Interviews were conducted in-person at either the therapists' place of employment or in a public place away from any other people. Each interview was scheduled for approximately 90 minutes but was generally conducted within the timeframe of 60 to 90 minutes, depending upon the length of the participants' responses. I first obtained the consent either in-person at the time of the interview or prior to the interview via email; once the

consent was received, the interview was conducted. Each interview was recorded using a Sony digital voice recorder for later transcription. I conducted all the transcribing. There was one variation that occurred during the data collection that varied from Chapter 3. Once the research was approved by the Institutional Review Board, there was an amendment submitted to be able to recruit participants from any outpatient clinics that met the criteria, instead of the two clinics that were approved on the original application by the IRB. This was done because there were not very many potential participants who responded to the initial advertisements that were posted in the original two out-patient clinics, and I wanted to be able to reach a large, more diverse population.

Data Analysis

The data and themes appeared to reach saturation with the eighth participant, and, therefore, the basis for understanding the therapeutic relationship between therapists and their female childhood sexual abuse survivor clients was drawn from the in-depth semistructured interviews of those eight therapists. From these interviews, the analysis process produced five main themes, with 17 subthemes.

The data were analyzed and coded according to the interpretative phenomenological method as outlined by Smith et al. (2012). Each interview was first transcribed and analyzed individually; IPA states that each interview be analyzed separately prior to examining themes across the interviews (Smith et al., 2012). Once all of the transcripts were transcribed and analyzed separately, they were then all analyzed together to identify themes and the relationships between the interviews.

Stage 1 of the data analysis consisted of carefully reading and rereading each of

the printed transcripts to ensure the participants were the focus of the study and to be fully immersed in the data (see Smith et al., 2012). Significant phrases were highlighted as initial themes emerged from the rich and descriptive responses of the participants. Comments were made in the margins, including phrases, keywords, and metaphors. Links to comments made through the course of the interview and minimal interpretation were also documented to preserve the integrity of the participants' experience. Comments and descriptive notes created during this process were transferred into electronic spreadsheets to help me manage the data more effectively.

The second stage consisted of noting emerging themes in the right-hand margin, reducing all textual data until essential themes emerged. These were defined uniquely to the phenomenon of the lived experience of the participants.

The third stage was to identify the commonalities better between the identified themes to identify subthemes; this was done using abstraction, numeration, and contextualization (see Smith et al., 2012). The entire transcripts were reviewed throughout this process to ensure emerging themes were consistent with the words and meanings of the participants.

The fourth stage was to repeat Stages 1 through 3 with each of the interview transcripts (see Smith et al., 2012), and once the subthemes were identified, I placed them under the appropriate essential theme. A table of the essential themes and subthemes was created to organize the data better. The themes and subthemes of each participant's experiences were analyzed to see how they related to one another.

Data Verification

To verify the data in this study, methods included member-checking and triangulation. Once the interviews were transcribed, each of the participants was provided with a copy of their transcript to ensure that their responses were captured accurately. Using the member checking method was extremely helpful as it not only provided clarification that was needed regarding responses to parts of the interview (see Harper & Cole, 2012) but also allowed the participants to make any corrections to the transcript due to audio error. Each of the participants received a copy of their transcript for review, and they sent it back with any changes that needed to be made due to audio error. For example, Participant 1 sent back her transcript with the name of the university she had graduated from with her master's degree and the name of one of the agencies she had worked at when starting her career. It was unclear when transcribing the audio, and, therefore, the participant corrected the transcript before sending it back.

The interviews were conducted in different environments (a park, outside a library, and a coffee shop), on different days, and different times of the day, away from other people to ensure privacy. The participants were recruited from different out-patient clinics in the Albuquerque Metro area.

Themes Identified

Five major themes emerged from analysis of the interview transcripts. These themes included ability to maintain boundaries, negative feelings and loss of self, emotional distress, the enhancing effects of disclosure, and empowerment. From these five main themes, 17 subthemes emerged (see Table 1).

Table 1

Themes and Subthemes

The enhancing effects of disclosure	Seeking to empower clients	The client's emotional distress	Negative feelings and loss of self	Ability to maintain boundaries
Contextualizing the abuse	Enhancing self-worth and sense of self	Preconceived ideas about therapy and trusting the process	Labels	Survivors need to understand the importance of maintaining a boundary
The importance of building trust, respect, and rapport	The need for professional and Relational Support	Safety to disclose	Social stigma and lack of understanding	Therapists' ability to maintain boundaries
Needing to be non-judging		Feelings of vulnerability	Blame and guilt	Insecurity leading to loss of boundaries
		The therapist needs to have a diverse skill set	Experience of the abuse	Continuity and consistency of the therapist

Evidence of Trustworthiness

As discussed in Chapter 3, trustworthiness is essential and is accomplished by applying methods to check the accuracy of findings, which is demonstrated by credibility, dependability, transferability, and confirmability (Lincoln & Guba, 1985). This study accounted for trustworthiness using multiple methods, including prolonged engagement, member-checking, reflexive journaling, triangulation, thick description, and an audit trail.

Credibility

One of the most important criteria in establishing trustworthiness is credibility (Lincoln & Guba, 1985). Credibility for my interpretative phenomenological research occurred through prolonged engagement, reflexive journaling, triangulation, and member-checking. To ensure credibility, interview procedures with each participant included my interview questions, digital voice recordings, and a manual transcription of each audio-recorded interview. Credibility was shown when each of the participants acknowledged that the research findings were their own lived experiences of the phenomenon.

Prolonged engagement requires the researcher to invest sufficient time to learn about their identified population. This includes gaining trust, and testing for any biases either from the research or the participants (Lincoln & Guba, 1985). In order to meet this requirement, I spent time building a rapport with each of the participants prior to asking the interview questions.

Reflexive journaling was used throughout the research process to assist in managing any researcher biases. This journal also served to notate any impressions in regards to the interviews and monitoring any developing constructions. One bias that I noted in my journal was regarding one of the participants. I had a personal bias regarding her practice because I was expecting all of the participants to reference differences in their practice when working with female childhood sexual abuse survivors. Participant 2 throughout the interview process kept stating that she did not treat her female childhood sexual abuse survivors any differently than any of her other clients. She could not identify any differences that she saw within that population, and while I wanted to

challenge her and ask more about her practice, that was not relevant to my research as my research was recording her lived experience with her female childhood sexual abuse survivor clients.

In triangulation researchers use two or more sources (Carter et al., 2014); this was achieved by having several participants that created a homogenous sample. It was also achieved by keeping the reflexive journal and minimal field notes as additional sources to refer to when analyzing the data.

Member-checking was used to measure the accuracy of the participants' responses. Once each of the interviews was transcribed and interpreted, each of the participants received a copy of their transcript to check for errors and to make sure the interpretations were captured correctly.

Transferability

Transferability refers to a way of achieving a type of external validity (Lincoln & Guba, 1985). Transferability was supported through rich descriptions obtained from participants that adhered to the research questions. This allows readers to understand not only my interpretation but also the reported findings. These rich descriptions included themes and sub-themes from the data and to support the development of the themes and sub-themes, the participant's words were used, this also provides the person reading the study to assess the transferability of the findings.

Dependability

Dependability refers to the stability of the data and inquiry process (Houghton, Casey, Shaw, & Murphy, 2013). Dependability is met when the researcher is able to

demonstrate that there were no mistakes and the researcher was careful when collecting the data, interpreting the findings and reporting the results (Houghton et al., 2013). To demonstrate dependability an audit trail which outlines a transparent description of the steps was used throughout the research process (Houghton et al., 2013). An audit trail was used to maintain the digital-voice recordings, transcripts, reflexive journaling, and the data related to the research process.

Confirmability

Confirmability was also obtained through careful documentation of coding the data, reaching saturation and the development of the themes. I kept good accurate records through reflexive journaling and an audit trail that can provide information so that the data can be traced back to the original source (Mertens, 2014). The audit trail also contains the complete raw data generated throughout the study, which will allow others to verify the trustworthiness of the findings (Lincoln & Guba, 1985).

Results

The purpose of this study was to have an in-depth understanding of the therapeutic relationship between the therapist and their female childhood sexual abuse survivor clients from the perspective of the therapist. Interviews were conducted in-person. The interview consisted of ten questions that were developed to answer the main three research questions: What are the lived experiences of therapist's working with female sexual abuse survivors in terms of their therapeutic relationship? How do therapists describe their therapeutic relationship with this population? How do therapists experience female childhood sexual abuse survivors as clients?

All of the participants interviewed were from the metro area in Albuquerque, New Mexico. Advertisements were placed in various out-patient clinics and on a social media website who's target audience is licensed therapists. After consent was obtained, each participant was interviewed; the interviews were allotted for one hour but generally took 60-90 minutes, depending on the length of the participants' responses. Each of the interviews was recorded using a Sony digital voice recorder.

Each of the eight participants were asked ten questions; these questions were derived from the main underlying reseach question: What are the lived experiences of therapist's working with female childhood sexual abuse survivors in terms of their therapeutic relationship? There were five essential themes that emerged from the participant's interviews: ability to maintain boundaries, negative feelings and loss of self, emotional distress, the enhancing effects of disclosure, and empowerment.

What are the lived experiences of therapists working with female sexual abuse survivors in terms of their therapeutic relationship?

Theme 1: The enhancing effects of disclosure. According to the participants, it is extremely rewarding when their female childhood sexual abuse client trusts them and they have developed enough of a therapeutic relationship that the client disclosures. P5 stated, "as a woman, you're not supposed to report these kinds of things. It's your fault that something like this happened to you…there's that stigma that's associated with it [mental health], but it doesn't have the lasting effects that childhood sexual trauma has on women and just sexual trauma in nature." Building rapport with the client allows the client to trust the therapist which in turn helps the client feel comfortable enough to

disclose, especially with a topic as sensitive as childhood sexual abuse. The sub-themes identified in order to get to that point are: contextualizing the abuse, trust, respect and rapport and non-judging. The client needs to feel safe and secure in order to disclose their trauma.

Subtheme 1.1: Contextualizing the abuse. Many childhood sexual abuse survivors have a problem contextualizing the abuse. They want to blame themselves and not the perpetrator. They have a problem talking about the abuse and sometimes are in denial that it even happened. They may not have be believed in the past by friends and family and may start to wonder if in deed the abuse actually happened; however, they also have problems in their current relationships and/or in other areas of their lives that they can't explain. P5 stated, "So, I guess it requires more time and more patience, and probably, I guess, being able to really work through those significant events and finding those grounding techniques, I guess, compared to a lot of the other stuff, doesn't require as much intense stuff as it does for the sexual trauma. You've got to get really deep into things, in order to really resolve those issues, versus, I guess, the other mental health issues don't require necessarily as much, digging into a lot of other things." Therapists help clients contextualize the abuse and put the abuse and other areas of their lifes that may have been effected by the abuse into perspective; they help the client connect the dots as to the past and present.

Subtheme 1.2: The importance of building trust, respect, and rapport. A therapeutic relationship is built on trust, respect, and rapport. All 8 participants reported that building the therapeutic relationship takes significantly longer to build with a client

that has experienced childhood sexual abuse than other clients. The clients appear to have a lot of trust issues as reported by P6, “There is a lot of trust issues. Oh, my goodness. A lot, a lot of trust issues. It's all about control. They have to have some control whether they have the perfect looking family or the perfect job. They're very perfectionist in their behaviors.” P2 states, “Well, I think the differences are, let me go back. Similarities would be definitely that they don't kind of trust their gut because they have this history of people telling them, "That's not true." Or being not believed but they know in their gut that something is wrong here. It's not right but everybody around, they're either ignoring it, hiding it, not doing anything about it. So they lose that connection to their guts.” It seems that female sexual abuse survivors have trust issues when entering into therapy. In the past, they may also have had a lack of respect from others and about themselves and towards others. The therapist can not only model what a healthy positive relationship is for the client but building a therapeutic relationship which is built on trust, respect, and rapport can also provide a basis for other relationships in the clients life.

Subtheme 1.3: Needing to be nonjudging. In general, people have a tendency to judge others. Female childhood sexual abuse survivors have a notion that the therapist is going to judge them; this can have a negative effect on the therapeutic relationship. P6 shares an experience she had in a therapy session, “Well, definitely clients towards therapists. Those assumptions that you're going to judge me. They think that I'm going to judge them or the things that they say to me. I'll give you an example. A specific client came and right at the end of one of their sessions even at working [inaudible], spewed out all of these things that happened the last 5/10 minutes and they know that there is a client

waiting and so forth. I then scheduled an appointment for them, "Hey, you know what, let's come back in a few days and we'll talk about this a little bit more. Let's schedule another session." I scheduled it, they didn't show up for two more weeks after that because it was hard, heavy information they threw out. I don't know how you were going to handle that. I didn't want to look at you. I was afraid you were going to look at me differently, a lot of that kind of stuff, that blaming game on their part." Childhood sexual abuse survivors feel that they have been judged their whole lives, whether this is actual or perceived, those feelings are real to them. In order for the therapeutic relationship to occur, the client needs to know that the therapist is not judging them or anything they say; therefore, it is important for the therapist to maintain their composure and not react to anything that the client is saying especially when it relates to their childhood sexual abuse experience.

Theme 2: Seeking to empower clients. It is important for female childhood sexual abuse survivors to feel empowerment; this is often done throughout the therapeutic process. The participants in this study shared that they are constantly building their clients up and changing their mindset so that they are enhancing their clients self-worth and sense of self and they are doing this with the use of professional and relational support.

Subtheme 2.1: Enhancing self-worth and sense of self. Most of these clients (CSA) have an issue with their self-worth and sense of self. P7 talks about her experience and thoughts on the sub-theme, "if you look at it globally, it would go again into the low self-esteem and self-confidence, you know, when they come in and they really don't like

themselves I think that's the general denominator, for them to learn how to reverse that and really to learn to value themselves and be able to mitigate these shame the victim stance, you know."

Subtheme 2.2: The need for professional and relational support. For the purpose of this study, I looked at therapists that work with female childhood sexual abuse survivors that were abused by a parent or guardian living in the home. Many of these clients don't have the relational support from their immediate family due to the abuse. They may have other kinds of relationships such as spousal but they may have issues within this relationship due to the childhood abuse and not know that is the cause. These clients need positive role models for these relationships and support that will not reject them. P4 states, "This might sound a little funny, and maybe it's because I'm older than a lot of younger therapists, but I almost take on a motherly sort of demeanor. Kind of like I'm a soft place to land. And it just takes, however long it takes, for them to know that I am not going to cause them any more additional pain when they start talking about it. That I want to soothe, I want to support, validate their feelings. And so if I start by validating just their daily feeling, their daily life, they're having trouble with friends or having trouble with one of the officers, or having trouble with just coping, then they can share that, it's safe. And that starts to build that therapeutic alliance where they know, okay I can trust her." P3 provides an example of how she addresses the trauma and support with her client, "the information you're giving me today and so it sounds to me like you're coming to me for trauma related issues and that is not a mental list that will follow you that means that you decided to get help and you need someone to support you

while you make these adjusted." It is really important for childhood sexual abuse survivors to have someone to listen to them and feel heard.

How Therapists Describe Their Therapeutic Relationship With This Population

Theme 3: Clients' emotional distress. It can be extremely stressful to talk about something as painful as childhood sexual abuse. Clients may have preconceived ideas about therapy and think that they will be reliving the trauma rather than processing it, learning how the trauma is effecting them today and skills to move past the trauma.

Subtheme 3.1: Preconceived ideas about therapy and trusting the process*.* Some therapists make boundary decisions based on preconceived ideas about whether the boundary decision is helpful to the survivor in general, rather then then considering the individual client's needs. Both the therapist and the client may have preconceived ideas about therapy, the therapeutic relationship, and/or the process. The therapist usually knows about the childhood sexual abuse prior to starting therapy as it is usually asked during the assessment and intake process. However, this may not be the reason the client comes in for therapy. P7 shares, "They may come in and they may talk about depression issues and work on that and as it progresses then they say "Oh, here is something else I want to disclose" they don't tend to come out with the sexual abuse issues right away I think this is something that has to grow." P5 gives a different perspective, as she facilitors groups with female childhood sexual abuse survivors, "With a counselor, sometimes, you feel like maybe you want to project into them like they have the answers for you, just on a one on one basis. But, if you're in a group, it doesn't necessarily have to be that way. The facilitator there is facilitating strength and comfort for everybody there

and allowing everybody to help one another in that setting to be less vulnerable together. Because when you're with a variety of people, even in a sexual victimization sense, if there's more people around, it's less likely to happen.” It is important to talk to the client about any preconceived ideas they have about therapy and the therapeutic process. It is also important to talk about expectations and identify achievable therapeutic goals that the client can feel good about accomplishing.

Subtheme 3.2: Safety to disclose. When working with childhood sexual abuse survivors, sometimes it is important to role model for these clients and that often means disclosing. P4 shares, “I honestly think that you need to be willing to self-disclose some. I mean, it's a fine line, you're not going to go talking about everything that's ever happened to you, that's not the purpose. But to let them know that you've been in some crappy situations yourself. And that there is a way that we can move through that, and then past it, and go on with life. And so I have some of the women whose children have been taken away from them, who were abused as children. I honestly know where they're coming from. And I'm like, "Oh, you had one of those kinds of mothers. Oh, my goodness. So did I." Yeah. And I think there's a genuineness in being willing to disclose a little bit. And then that makes it safer also to talk. Yeah.” P5 shares, “I just feel like in the longrun, it's about, with this specific popuation is, it's just creating a comfortable and safe environment that's going to be conducive, whether it's individual counseling, or in a group process. Like I said, I'm a firm believer in the group process just because I've seen how it has changed people significantly, to know that they're not alone. Because it is sometimes intimidating to sit there, just across from a stranger, and to tell them your

whole life story and to be vulnerable by yourself, with somebody else. Versus, if you are in a group, there's, whatever size of group you're in, you're not vulnerable by yourself. You're vulnerable there with a whole bunch of other individuals who have dealth with the circumstances in a bunch of different ways, versus yourself, which is empowering, because we've all made it."

Subtheme 3.3: Feelings of vulnerability. Childhood sexual abuse survivors are a vulnerable population to work with; they have a fear od being exposed by sharing their story. The therapists can also have a fear of exposure especially if they don't feel fully skilled in working with this population. P6 shares her fear when first working with this population, "And I'll tell you that those two were the ones that terrified me the most as a therapist because I'm like, I don't know if I wanted to say that I felt like they were more fragile. But in some ways they are maybe in a different way. Just there's a different vulnerability there. And so I was like, "Oh my goodness. Oh my goodness. How am I going to handle this. How do I support them effectively." P5 shares her experience working in a group setting with this population, "So, when you have more people in that group setting, you don't necessarily feel like the person across from you is going to take advantage of your vulnerabilities if you're in a group setting. You can expose those and be okay to know that there's other people there and it's not just you one on one with somebody else that you don't know, and you're completely vulnerable. To me, that has just been what I have experienced, is that when you're vulnerable with other people, you want to learn to grow together. So, I really like having these discussions in a group setting, more than individually." P1 has worked a lot with clients that have a fear of

exposure, “So that's kind of what we do generally through counseling with a survivor. What's really interesting is that in the beginning, they may be hesitant to talk about that which I certainly respect and understand that and even minimizing it. I think things like, "It wasn't that bad." or "I got through it." But I will return the conversation to that multiple times until we can find a way to gently talk about that.” The client needs to be in a place where they can trust the therapeutic relationship and the therapeutic process. They are able to put themselves in a vulnerable place by telling their story and still feel safe sharing their story.

Subtheme 3.4: The therapist needs to have a diverse skill set. The majority of the participants spoke about how when working with this population they have a tendency of regressing back to the age that they were when they were abused. P6 shares her experience, “Yeah. It's like a digression, I guess, or some sort of regression, you know?...so if you ask like a four-year-old what happened, they know how to tell you but they go around the whole mountain before they actually get there. Does that make sense?” The therapist has to be diverse in their therapeutic practice because quite often an adult female childhood sexual abuse survivor they regress to their former self when sharing their experience.

Theme 4: Negative feelings and loss of self. The theoretical basis for this research was based on Bowlby’s (1973) attachment theory which suggests that children seek out safety and security from their primary caretakers; this is how children develop an internal working model of themselves and others. They learn to trust and build relationships with others; this builds self-confidence and a healthy self-esteem. Since

these females may have not developed a positive healthy internal working of themselves and others due to their early childhood experiences, this can result in their lack of interpersonal relationsips and lack of self-confidence and self-esteem.

Throughout the interview process, all eight participants talked about sub-themes that related to the clients negative feelings and loss of self. These sub-themes were identified as being: labels, social stigma and lack of understanding, blame and guilt, and experience. All four sub-themes impacted the therapeutic relationship as they all impacted the way the client shared their story and how the client felt about themselves; it also impacted the way the client expected the therapist to feel about them.

Subtheme 4.1: Labels. Labeling refers to assigning something to a category and this can be done inaccurately and/or restrictively. There are a lot of labels used when referring to sexual abuse and the rational as to why the abuse occurred. The labels are often negative in nature and result in the client having concerns about how the therapist will receive them, this often results in the client taking longer to share their abuse. P7 stated, "when it comes to childhood sexual abuse right, I mean society puts all these labels like well you know like, what was she wearing, why was she wearing makeup, so it, so it was very much, so it was very much societal and community assumptions that are embedded within this population."

Subtheme 4.2: Social stigma and lack of understanding. It is offered believed that female sexual abuse victims shouldn't talk about their abuse, this not only happens within the family unit but society in general. Quite often the abuse is not believed and there is usually a stigma associated with the abuse. If it isn't believed then the thought is

the victim is making the story up for attention. If the abuse is believed then the stigma associated with the abuse is that it's the fault of the victim. P5 stated, "I feel like, with this population specifically, the therapeutic relationship is the most imperative piece, for the simple fact that women are-- they need to be nurtured, they need to be understood, they need to be heard in order to feel comfortable to disclose it, because the shame and the guilt and the stigma already associated with being reporters, they're automatically victimized by other people, so the therapeutic relationship definitely has to be the most imperative in order for them to even begin to trust you and divulge past traumatic experiences." "I guess, maybe the biggest problem, I guess, is the stigma, I guess, that's associated with it, moreso than anything just because, as a woman, you're not supposed to report these kinds of things. It's your fault that something like this happened to you. Versus the other mental health issues, yes, there's that stigma that's associated with it, but it doesn't have the lasting effects that childhood sexual trauma has on women and just sexual trauma in nature. So, I guess it requires more time and more patience, and probably, I guess, being able to really work through those significant events and finding those grounding techniques, I guess, compared to a lot of the other stuff, doesn't require as much intense stuff as it does for the sexual trauma. You've got to get really deep into things, in order to really resolve those issues, versus, I guess, the other mental health issues don't require necessarily as much, digging into a lot of other things." The stigma, either real or perceived, was reported as having a large impact on building a therapeutic relationship.

Subtheme 4.3: Blame and guilt. When the participants talked about building their

rapport and therapeutic relationship with their female childhood sexual abuse survivors, a common identified sub-theme was blame and guilt that the client felt. Some survivors experienced their family not believing them or the family member being in denial that something like that could happen in their home and some of the survivors had been blamed in the past and therefore, blamed themselves that the abuse was somehow their fault. The blame and guilt the client felt appeared to be a barrier to establishing and building a therapeutic relationship. P6 stated "The persona of family, especially if the family lived a certain way and the family's in denial of any kind of abuse, especially when it's a non-family member. Maybe it's a close family friend or somebody from outside the family that's harmed them, and then sometimes you see that. Then there's blame on the child if the family's like a specific way… but it's almost like you're seeing it because there's-- and then you end up finding out it was generational. The mom herself was abused. The grandmother was abused."

Subtheme 4.4: Experience of the abuse. The overall experience of the abuse and then the perceived stigma associated with therapy has an impact of therapeutic relationship. Many of the participants explained to me that they have to change the survivors mindset and sometimes they use their own personal disclosures to overcome this barrier and build rapport with their clients. Due to the clients past sexual trauma, the participant also talked about being vigilant and not pushing their clients and also talking about topics that they may not normally discuss in a therapy session. P7 provides an example of how they would encourage and educate their client without pushing them, "maybe explain to them the thought process that they feel that way because what

happened in the past, are you willing to talk about it, are you happy with the way you feel, do you want to make a change, if they say "yes" then okay and we can talk about that, you know, because of maybe you were abused and you were put down your self-confidence, self-esteem is really low, do you want to change that, if you see something you may overreact because of your past experiences. Or yeah, they come in and say "oh well, I don't know why I'm so angry at something, it was a small thing" why are you feeling and overreacting to something minor, what led you to that and then you can go back and work on that." P2 provides an example of a topic she may not normally discuss in a therapy session but does when working with this population, "I think we'd definitely talk about sex more. I think that's something that really comes up a lot because they're in relationships and it's going to be affected by their history and things like that. And I think if they're there with me, I don't want to make it my agenda if it's not theirs but try to help them create a healthy relationship with sex if there's a problem it's been damaged by the trauma. So that usually tends to fall to one of our goals of really working on having a healthy relationship with sex. I think it's the only thing that really stands out… Yeah, right, how that rewires your brain to be so hyper-focused on sex or hyper-vigilant against sex. All of that stuff that they don't know how to regulate as a child but they now probably have no idea subconsciously what they're playing out in the bedroom or in their sexual relationships and stuff, so. That typically comes up a lot. The book, The Body Keeps the Score, going through stuff like that and just helping them have a sex life."

How Therapists Experience Female Childhood Sexual Abuse Survivors as Clients

Theme 5: Ability to maintain boundaries. According to all eight participants, it

is important for therapists to maintain boundaries when working with female childhood sexual abuse clients. This could be due to the lack of boundaries the survivors' family member showed. The survivor did not experience good positive boundaries as a child due to their role model and many times this can also affect their interpersonal relationships.

Subtheme 5.1: Survivors need to understand the importance of maintaining boundaries. All eight participants reported boundary concerns/issues when working with female survivors of childhood sexual abuse. P1 stated "although you have to maintain your boundaries, at the same time, they're testing you, whether they're conscious of that or not," "they're" being the client, have a hard time with boundaries because when it comes to the abuser, for the purpose of this study, the parent/guardian "they break all the boundaries, all the rules" (P1). P3 expressed the same concerns with survivors understanding the importance of maintaining boundaries, "I don't even think that they realize sometimes that their crossing boundaires." Many of the participants expressed that while it is important that childhood sexual abuse survivors need to understand the importance of maintaining boundaries, many times the clients are not aware or realize that they are even "testing boundaries" (P7).

Subtheme 5.2: Therapists' abilities to maintain boundaries. All eight participants also reported the importance for therapist to maintain boundaries in order to build a rapport and have a healthy positive therapeutic relationship with this population. When asked the question, "How do you build rapport with this population" P5 explains "you have to have very strong boundaries with this population because of their ability to, at times, want to manipulate in order to get them out of that victim role and more so in

the survivor role because a lot of women do want to stay stuck in that victim role and don't want to embrace that piece of it." P3 explained that she finds "that I have to constantly be on top of boundaries because often boundaries are quite an issue so I have to create boundaries, set boundaries, explain I'm setting boundaries, enforce the boundaries…reestablishing those boundaries." This may be the first time many of these clients have had these types of boundaries set, "Healthy boundaries, because they've never had them, for the most part" (P6). P2 stated that "this is a trauma survivor, therefore, I need to be cognizant of boundaries and to make sure that there's that comfort level so I don't push boundaries to retraumatize them." While this may be true for other types of trauma client's and not just childhood sexual abuse client's, this is still an area that therapist's need to be mindful off.

Subtheme 5.3: Insecurity leading to loss of boundaries. According to the majority of the therapists that were interviewed, this population when testing boundaries will reach out to their therapist between appointments usually by telephone. P1 explains that the her theory behind why this population attempts to contact their therapist between appointments is "they call outside of normal hours…because like I said, they want to know if your're really in this for the long haul because they've been in it for the long haul, and maybe they're finally ready to do something and they don't want to carry that burden around anymore. So they need somebody who's going to walk down this road with them and somebody who's going to stand by them." It is important for the therapist and client to establish boundaries and rules pertaining to therapy, especially contact between appointments prior to starting therapy.

Subtheme 5.4: Continuity and consistency of the therapist. Participants shared the importance of continuity and consistency with this population especially since this population takes longer to build a therapeutic relationship than non-childhood sexual abuse clients. P5 explains “the boundaries, the time, the patients, takes a lot longer than it does with the regular population just because of the extent of the trauma and the inability for females to trust people in general, especially in a therapeutic relationship.” While it may take longer to build rapport with this population, providing the client with continuity and consistency allows them to proceed at their own pace and talk about the trauma when they are ready. P1 provided an actual client example, “without going into too much detail about one woman I worked with she, there was that minimization thing kind of about, "Oh, it wasn't that bad." But I had a very strong feeling yes, it was that bad. And, of course, any type of sexual abuse is that bad. So I would lead the conversation a little bit back to that, and touch on it, to see if she was willing to talk about it. We didn't have to go over all the details, but I wanted her to recognize, I think that it was important that we recognized the abuse for what it was. And not that "It's not that bad." "I handled it." "I dealt with it." That we needed to return to that space a little bit to acknowledge it, to validate it for what it was. So just that process alone takes a lot of time until then. One day, and it may sound odd, but I felt it coming, that she was willing to talk about it. And we talked about it and that was a big breakthrough because she was really acknowledging the power that it did have in her life. And just to get to that point took time to arrive at that space. And then once we did, to acknowledge the power that that had in her life and then we could take a look at also the reason why she had married three very abusive men.

And to look at how the power of the past still has power in the present."

Discrepant Cases

Seven out of the eight participants all expressed the same common themes with regards to their work with female childhood sexual abuse survivors. They all reported that it took longer to develop rapport and trust in the therapeutic relationship and spoke about the regression their clients experience when discussing their childhood sexual trauma. Only one participant, P2, felt that building trust and rapport was the same for all of her clients regardless of their history or trauma. According to the interview and transcript, it also appeared that P2 had not experienced any type of regression with the female clients she had on her caseload that were survivors of childhood sexual abuse. It is unknown as to why this participant felt there was no differences between working with female childhood sexual abuse survivors and her other clients. While she did meet the criteria for the study, she may have still be fairly new working with this population and/or working independently with this population. She may also not want to find fault in her practice and want to believe that all of her clients are successful and have healthy positive relationships.

Summary

The sample for this study consisted of eight licensed therapists who self-identified as being: a therapist that is licensed according to the New Mexico Therapy and Counseling Board; treating adult female survivors of childhood sexual abuse in an out-patient setting; has treated 2 adult female survivors of childhood sexual abuse within the last year; has treated at least 10 adult female survivors of childhood sexual abuse

throughout their career; has female survivors on their caseload that were abused for a minimum of six months between the ages of 5-17 years of age by a parent or guardian living in the home; and that is fluent enough in English to be able to participant in the interview process. The participants were recruited with the use of recruitment informational letters being posted in the Metro Albuquerque area of New Mexico, postings on social media and snowballing sampling strategy. After consent was provided, semi-structured interviews took place.

During the interview process, several themes emergered to answer the research questions. The therapeutic relationship between therapist and their female childhood sexual abuse clients, from the perception of the therapist, were influenced by ability to maintain boundaries, negative feelings and loss of self, emotional distress, the enhancing effects of disclosure, and empowerment.

Chapter five provides an interpretation of the findings, limitations of the study, recommendations for further research, implications for positive social change, and conclusions.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The goal of this interpretative phenomenological study was to gain an in-depth understanding of the how childhood sexual abuse affects the therapeutic relationship, and this was done by looking at the experiences of therapists who work with adult women who are survivors of childhood sexual abuse. Due to childhood sexual abuse, female survivors tend to have an abundance of adult relationship problems; this is due to the insecure attachment they formed during their childhood (McCarthy & Maughan, 2010). Trauma that is related to abuse tends to provoke negative feelings in the individuals who have experienced abuse (Baljon, 2011); this is direct result of the child having feelings of fear, anxiety, neediness, confusion, and insecurity at the time the abuse occurred (Muller et al., 2012). Preliminary research has revealed that these feelings have a tendency of becoming apparent in adult relationships; however, it is unknown as to how this type of childhood abuse in female adults affects the therapeutic relationship.

The eight participants in this study had experience working with female childhood sexual abuse survivors. Five main themes and 17 subthemes emerged during constant comparative analysis of the interview data, which I review in this chapter in relation to existing literature and research. This chapter includes a discussion of the results, including an interpretation of the findings; the limitations of the study; recommendations for further research; a consideration of the study's implications; and a conclusion to the study.

Interpretation of the Findings

Participants in this study discussed their experiences as therapists who work with female childhood sexual abuse survivors. In my analysis, I identified five descriptive themes: the enhancing effects of disclosure, seeking to empower clients, the client's emotional distress, negative feelings and loss of self, and ability to maintain boundaries. I synthesize the findings presented in Chapter 4 with pertinent literature identified in Chapter 2.

Theme 1: The Enhancing Effects of Disclosure

Riggs et al. (2011) emphasized that children subjected to sexual abuse are at increased risk for behavioral, social, interpersonal, and psychological functioning issues. Physical and emotional unresolved childhood abuse is associated with lifelong struggles with emotional disturbance, including poor affect regulation and difficulties with interpersonal relationships (Riggs et al., 2011). My research findings aligned with those of these authors; this population has interpersonal issues, and this was demonstrated in the therapeutic relationship. Many times, the survivor has problems establishing trust, and therapeutic relationships take time to establish and build. There are many obstacles that the therapist must overcome when working with this population, such as the client's preconceived ideas about therapy, trust issues, and boundaries issues as identified in themes of this research.

Various types of attachment have been explored over the years in research. Researchers have provided information of the different types of attachment and how the different types can affect a person in adult life. A child forms negative attachment and bonds when they have been sexually abused by a household member. Murphy et al.

(2016) identified that survivors of childhood sexual abuse can develop trauma bonds, which can affect the survivors' relationships later in life. This posttraumatic stress symptomology tends to interfere with a person's emotional, cognitive, and social functioning (Courtois & Ford, 2009). This was shown to be true in the current research; the participants reported their clients as having a lot of trust issues when forming relationships and negative feelings about themselves. This also aligns with research that was conducted by Crawford and Wright (2007) and Muller et al. (2012).

The participants also reported that another barrier to developing a therapeutic relationship with survivors of childhood sexual abuse is needing to be nonjudging and enhancing self-worth and sense of self. This would align Reiff et al.'s (2012) who found that individuals with childhood sexual abuse were unable to self-regulate their emotions and feelings, which also included suffering with negative self-esteem and feelings of fear. This also aligned with Murphy et al. (2016) who also found that survivors of childhood sexual abuse can internalize and integrate feelings of self-doubt and ideas of being damaged and unlovable.

Theme 2: Seeking to Empower Clients

In this current study, I found that it is important to empower these clients and the need for professional and relationship support. This aligns with Joiner's (2005) and Milulincer and Shaver's (2012) research that survivors of childhood sexual abuse do not always seek out emotional connections, and this can lead to a sense of loneliness, which can contribute to low self-esteem and suicidal ideation. Part of the barrier to building a therapeutic relationship with these clients, according to therapists, is their self-esteem and

self-worth. These barriers align with the research conducted by Muenzenmaier et al. (2010), O'Leary and Gould (2010), Quina and Brown (2007), and Reiff et al. (2011). They all found that when an individual is a survivor of childhood sexual abuse and the feelings, emotions, and unresolved issues associated with that trauma have not been resolved, the individual can have a limited capacity for coping, maintaining relationships, low self-esteem, and a negative internal awareness of themselves and others. In the literature review, I found that a number of researchers (DiLillo et al., 2007; Whishman, 2006) who reported that survivors of childhood sexual abuse had increased relationship problems, and this was also associated with low marriage satisfaction. It makes sense that survivors of childhood sexual abuse would have problems with developing and/or maintaining a therapeutic relationship.

Theme 3: The Client's Emotional Distress

Participants in this study reported that while their clients need to feel safe to disclose, they also have feelings of vulnerability and preconceived ideas about therapy. These concepts align with Bartholomew et al. (2001) who found that childhood sexual abuse survivors do seek approval from others, and Muller (2009) and Buckley (2013) found that these types of clients do have a fear of rejection. During the literature review in Chapter 2, I found no literature that addressed childhood sexual abuse survivors' regression to the age of which they were abused, which was identified by the participants of this study. Because this was not identified in the literature review, this is new and significant because therapists working with this population need to have a diverse skill set so that they are able to meet the client's needs as an adult client but also have the

ability to work with the client when they regress and meet the client's needs as a child. There was also no literature found that addressed the need for the therapist to self-disclose. While attending school to be a therapist, it is usually taught that therapists do not self-disclose because the focus needs to be about the client. However, in this research, I found that according to the participants, it is sometimes important for the therapist to self-disclose so that the sessions are meaningful and helpful to the client when working with survivors of childhood sexual abuse to build that therapeutic relationship and allow the client to overcome their feelings of vulnerability and start trusting the therapeutic process.

Theme 4: Negative Feelings and Loss of Self

This current research aligns with the research that Hall and Hall (2011) conducted showing that there was a correlation between childhood sexual abuse and self-blame, among other aspects. The participants reported that their clients showed blame and guilt about their abuse. According to the participants in this study, their clients also reported social stigma and lack of understanding and experience of the abuse, where the therapist helps the client change their mindset and understands and conceptualizes the abuse for what it really is, abuse; this aligns with research that was conducted by Alaggia and Millington (2008). This also aligned with the research that O'Leary and Barber (2008) conducted that showed that while females tend to be more prone to disclose trauma associated with sexual abuse then their male counterparts, they are still very much reserved in discussing experiences or seeking help regarding their childhood sexual abuse. Simon, Fiering and Cleland (2016) reported that many survivors feel ashamed,

embarrassed, or guilty and will never report the abuse; this is similar to what the participants in my study reported. The participants in my study also reported that their clients felt that they should not talk about the abuse for various reasons, such as not being believed, that the abuse was their fault, and concerns about the potential stigma impacting the therapeutic relationship. Simon et al. also mentioned that survivors of childhood sexual abuse may internalize the abuse and believe that the abuse was their fault. This can happen for a number of reasons, including the fact that some professionals and family members may have also believed the survivor was not the victim but actually encouraged the abuse because of their behavior, their attire, and/or their choice of entertainment. However, it is important to note that regardless of the reason for the clients seeking out therapy, the participants in this study reported that they did report the abuse. This could be because of media attention and also the therapists educating their clients and conceptualizing the abuse while building and maintaining a therapeutic relationship. It could also be because the therapy has helped the clients take more control of their lives, in terms of deciding whether or not to report the abuse.

Theme 5: Ability to Maintain Boundaries

While there was nothing specific in my literature review showing that researchers identified as childhood sexual abuse survivors having or not having the ability to maintain boundaries, the participants in my study identified this to be a theme. The only alignment I identified that was similar in the literature is the research conducted by Buckley (2013) where the researcher identified childhood sexual abuse survivor clients having a fear of loss, separation, being alone, and too much independence. Buckley

identified their fear of rejection and that the survivors have a tendency of overexaggerating their distress to fulfill their need for attention. These clients have difficulty expressing their emotions and can exhibit some borderline traits. These borderline traits would correlate with their ability to maintain boundaries.

There were many parallels between this research and research that addressed other types of relationships and with other types of childhood abuse. Childhood trauma can limit an individual's capacity to develop healthy attachment in adulthood (Balijon, 2011; Muller et al., 2012). Participants reported that the therapeutic relationship took longer to develop with their clients who had a history of childhood sexual abuse versus clients who did not report any type of childhood trauma. This aligns with Riggs and Kaminski's (2010) research that addressed secure attachment leading to the development of safe and secure adult relationships. This also aligns with Laughton-Brown (2010) who looked at the trust aspect of the therapeutic relationship.

This study was guided by Bowlby's (1973) attachment model, which was conceptualized in a traumatic framework. Many of the findings of this research can be contributed to the client's attachment and/or trauma, which is why attachment theory was ideal for this study because it was used to explain how interpersonal relationships are developed and maintained. A large factor in this research is emotional disturbance, and various factors such as low self-esteem plays into barriers that contribute to the therapeutic relationship. Many of the studies reviewed in the literature review addressed emotional disturbance and how this was a result of the clients' childhood attachment. Participants reported many factors that indicated that childhood abuse with their clients

had led to insecure attachment, which in turn leads to the many factors that have affected the therapeutic relationship, including poor boundaries, the need for professional and relational support, and feelings of vulnerability.

Limitations of the Study

This study provided valuable in-depth data describing the lived experiences of therapists working with female childhood sexual abuse survivors to better understand the affects that childhood sexual abuse has on the therapeutic relationship; however, this study has several limitations. While the demographics of the participants were not recorded, this study focused on therapists working with female childhood sexual abuse survivors. Therefore, this limits the results to therapists only working with females and not male childhood sexual abuse survivors. Also, while the recruiting participants was open to any therapist that met the study requirements, all eight of the participants that responded and participated were female therapists. It would have been informative to know how the therapeutic relationship is affect when the therapist working with female childhood sexual abuse survivors is male. This research study only solicited from the Albuquerque Metro area and therefore cannot be generalized to a larger population without further research.

The study also focused on the therapeutic relationship and not on any type of therapeutic modality. Since the focus is not the therapeutic modality, it will not be known as to whether the modality effects the therapeutic relationship. Some of the participants could have been less forthcoming in their responses and although confidentiality was

priority, many individuals could have been more conservative in their responses as an attempt to maintain their sense of anonymity.

Recommendations

Based on the strengths and limitations of this study, some recommendations are proposed for further research. First, additional phenomenological studies should be conducted to examine the effects of the therapeutic relationship of childhood sexual abuse survivors when the client is female and the therapist is male, when the client is male and the therapist is female and when the client is male and the therapist is male. Thereby, taking gender into consideration and looking at the affects that childhood sexual abuse has on the therapeutic relationship regardless of gender.

Second, this research only looked at therapists that work in the Albuquerque Metro Area and thereby limits the results. More studies are needed in other demographic areas as to broader the findings and compare the findings of this research to see whether the results can be generalized to a much broader population.

Third, additional research looking at cultural factors would be important. Different cultures accept different societal norms. It would be important to look at not only how other cultures view childhood sexual abuse, the therapeutic relationship but also how culture affects the therapeutic relationship when the client is a survivor of childhood sexual abuse.

Fourth, it would be important to interview the clients themselves, to get their take on the therapeutic relationship. It would also be enlightening to interview both the therapist and client during the same study and compare how the therapists and clients

both perceived the same relationship to understand the therapeutic relationship better.

Lastly, it would also be informative to learn the backgrounds of those working and having a successful therapeutic relationship with this population. It would be interesting not just to know the demographics of the therapists but whether they had their own childhood trauma.

Implications

A number of implications emanate from the study's findings with regard to positive social change. This study adds to the knowledge base of qualitative research concerning the effects that childhood sexual abuse has on the therapeutic relationship. This research was undertaken, in part, because of the significant gap found in qualitative literature pertaining to how childhood sexual abuse affects the therapeutic relationship. While the findings from this study will not eliminate childhood sexual abuse, having a better understanding of the affect that childhood sexual abuse has on the therapeutic relationship will allow service providers, such as therapists to develop programs to support therapists in developing better relationships with these clients.

It is important to understand the therapists' experience when working with this population, as the relationship they develop with their clients is crucial to their clients' progress. This study is unique because it addresses the lack of research and knowledge about the lived experience of therapists that treat female childhood sexual abuse survivors (Parry & Simpson, 2016). Research shows that individuals who have experienced abuse during childhood tend to experience feelings of fear, neediness, anxiety, and insecurity. These issues characterize insecure adult attachment styles and relationships (Baljon,

2011; Muller et al., 2012), and can therefore drastically impact the therapeutic relationship.

Looking at the results of this study, it is important that therapists understand that building a therapeutic relationship with survivors of childhood sexual abuse will usually take longer and will be harder to maintain. It is important to let the client know what the expectations for therapy are and develop realistic, obtainable goals with the client. The therapist needs to work with client in forms healthy relationships outside of therapy that they can develop and maintain once the client is discharged. It is also important that the therapist provides the client a safe, secure environment and encourage the client, in their own time, with support the ability to disclose their abuse and be present and non-judging once they do disclose.

With The National Center for Victims of Crime (2012) reporting that childhood sexual abuse is increasing, there is the potential for an increase of people, childhood sexual abuse survivors seeking therapy. The results of this research can assist therapists working with this population in developing awareness and education resources, to increase effectiveness of treatment given to adult survivors of childhood sexual abuse.

Through supporting therapists with developing better relationships with their clients' positive social change will result. When therapists can build a rapport with their clients and develop better relationships, this has the potential of increasing successful treatment outcomes and allowing clients to build better external positive, healthy relationships. Hence clients and their families can have healthier relationships.

Conclusion

Current literature has not adequately or thoroughly addressed the effects of traumatic experiences such as physical and sexual abuse during childhood on the adult attachment and the therapeutic relationship among female sexual abuse survivors and their therapists. Research based on women has found that childhood sexual abuse, childhood violence, and childhood stressors impacted relationships in adulthood (Walker et al., 2009). Individuals who have experienced abuse during childhood tend to experience feelings of anxiety, fear, neediness, confusion, and insecurity, which are prevalent in insecure adult attachment and relationships (Baljon, 2011; Muller et al., 2012).

Implications for social change include adequately addressing issues and exploring the therapeutic relationship. This research highlights a topic that does not get much attention. This research provides support and education for those therapists that provide direct services to female survivors of childhood sexual abuse who struggle with mental health.

This study sought to extend the current literature about the therapeutic relationship and how childhood sexual abuse affects that relationship. The IPA of this research allowed for in-depth responses from a specific population. The five main themes that emerged included: the enhancing effects of disclosure, seeking to empower clients, the client's emotional distress, negative feelings and loss of self, and ability to maintain boundaries. These themes can serve as additional suggested research for future quantitative and qualitative studies, and can inform mental health professionals on ways to improve therapy, specifically the therapeutic relationship for this population. Ideally,

this research will begin to fill the current void in the area of research on how childhood sexual abuse affects the therapeutic relationship. This current research study will help provide avenues for social change and develop ways in which support can be employed to serve the affected population through education and rapport building, which in turn has the potential of increasing successful treatment outcomes which allows clients to build better external positive, healthy relationships.

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Appendix A: Recruitment of Participants

Study about the Therapeutic Relationship and how Childhood Sexual Abuse Affects It.

My name is Tracy Hollingworth, and I am a doctoral student of Psychology at Walden University. I am conducting this study for my PhD dissertation. You are invited to participate in a research study which aims to explore the lived experiences of therapists who work with adult women who are survivors of childhood sexual abuse. The study is intended to understand the effects that childhood sexual abuse has on the therapeutic relationship.

The intent behind this study is to understand how childhood sexual abuse affects the therapeutic relationship. Your shared experiences will help develop awareness and education resources for therapists, to increase effectiveness of treatment given to adult survivors of childhood sexual abuse. It will help provide avenues for social change and develop ways in which support can be employed to serve the affected population through education and rapport building, which in turn has the potential of increasing successful treatment outcomes which allows clients to build better external positive, healthy relationships.

In you are interested in participating, the interviews will be conducted either in-person or with the use of a free internet-based software (e.g.., Skype, Hangouts) and a webcam to help build rapport. The interviews will take no more than an hour. Your identity will be protected so any data collected and reported will be anonymous. I will not ask for information about specific clients you have now or have helped in the past.

You may be eligible to participate in this study if you can answer YES to all of these

questions:

- I am a therapist that is licensed according to the New Mexico Therapy and Counseling Board.
- I am treating adult female survivors of childhood sexual abuse in an out-patient setting.
- I have treatment 2 adult female survivors of childhood sexual abuse within the last year.
- I have treated at least 10 adult female survivors of childhood sexual abuse throughout my career.
- The female survivors on my caseload were abused for a minimum of six months between the ages of 5-17 years of age by a parent or guardian living in the home.

All selected participants must be 18 or over and meet the above criteria

If you would like to participate in this study, please email me at tracy.hollingworth@waldenu.edu to express your interest, ideally within 7 days of receipt of this correspondence. When I receive your email, I will send you detailed consent form that will require your signature. Once you send the signed consent form back to me, we will set up a time for the interview.