Exploring the role of relationships in complex trauma: A systematic review of the therapeutic relationship and an IPA study on personal relationships

Caroline Mangham

Candidate Registration Number: 4140036

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University of East Anglia

Faculty of Medicine and Health Sciences

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Thesis Portfolio Abstract

Background: Complex trauma, often rooted in early childhood adversity, disrupts attachment and relational functioning. Individuals who experience complex trauma frequently struggle with emotion regulation, identity, and interpersonal relationships. Relationships have been considered both challenging and fundamental for recovery.

Aims: The first aim of the thesis was to synthesise research exploring the qualities of the therapeutic relationship from the perspective of individuals with complex childhood trauma histories and therapists. The second aim was to qualitatively explore the experiences of the impact of complex trauma on personal relationships in individuals with complex trauma.

Methods: A systematic review of 12 qualitative studies was conducted to explore the qualities in therapeutic relationships with individuals with histories of complex childhood trauma and therapists, using a narrative synthesis approach. An empirical study explored the lived experiences of the impact of complex trauma on personal relationships. Semi-structured interviews were conducted with ten research participants. Interpretive Phenomenological Analysis was used to analyse the data.

Results: Six themes narratively synthesised findings in the systematic review: The core foundations are fundamental, From chaos to coherence, Therapists with courage, We are in this together, Boundaries, and A new attachment relationship. The empirical paper identified four Group Experiential Themes and related subthemes: The void of attachment needs, Inner narratives that shape our relationships, Challenges in relating with others, and Change and growth.

Conclusions: Both studies showed that complex trauma profoundly disrupted relational functioning and attachment. Adaptive relational experiences, whether therapeutic or personal, supported healing and growth for individuals with complex trauma.

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Chapter 1: Introduction

Chapter 1: Introduction

This chapter will introduce complex trauma and consider the role of interpersonal relationships. The challenges of conceptualisation will be discussed, and the complexities of working with complex trauma in research and clinical settings will be introduced. The Power Threat Meaning Framework and Trauma-Informed Care will be explored. Developments in therapeutic approaches with complex trauma populations will be considered. Finally, the systematic review, empirical paper, and additional chapters will be presented.

Developing an understanding of Complex Trauma

Traumatic events have been defined as exposure to death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence (APA, 2023; WHO, 2019). Events are usually associated with extreme senses of threat and powerlessness. The experience of trauma can impact an individual's beliefs, leading to a loss of control, a perceived sense of vulnerability and lack of safety in the world, and loss of trust in others (Janoff-Bulman, 1992; Kleber, 2019). Single-incident trauma is often linked to experiencing or witnessing a traumatic event such as rape, assault, combat, an act of terrorism, or a natural disaster (Kleber, 2019).

Since the emergence of trauma research, there have been advancements in the understanding of complex trauma (Maercker et al., 2022). Research in this area began with the differentiation of Type 1 traumas, which related to single-incident experiences and the development of Post Traumatic Stress Disorder (PTSD) (Kleber, 2019), and Type 2 traumas, which referred to repeated, longstanding events that led to a range of complex difficulties, including denial, dissociation, rage, self-destructive behaviours, and overwhelming sadness (Terr, 1991). Since this time, researchers and clinicians have sought to differentiate complex trauma from single-incident trauma, leading to an increased understanding of complex

trauma's distinct difficulties and aetiologies. Complex trauma typically involves prolonged or repeated exposure to traumatic events, often occurring in early life, within interpersonal contexts. Complex trauma is a term that describes the original traumatising events and subsequent psychological, emotional, and relational impacts (Kliethermes et al., 2014)

Interpersonal relationships and complex trauma

Interpersonal relationships are social and emotional connections that develop between two or more individuals through interaction, communication, and mutual influence. They encompass a wide range of relational contexts, including family, friendships, romantic partnerships, professional associations, and caring relationships. Relationships are characterised by varying degrees of closeness, trust, reciprocity, and emotional involvement (Hinde, 1997). From a psychological perspective, interpersonal relationships serve fundamental human needs for belonging, support, and identity formation (Baumeister & Leary, 1995). Such needs are associated with optimum mental health and well-being (Baumeister & Leary, 1995). Interpersonal relationships are dynamic and reciprocal, where individuals contribute to the development of relational systems and are subsequently shaped by their relational experiences.

Interpersonal relational experiences are widely acknowledged as central to the development of complex trauma (Levy & Orlans, 2014; Cloitre et al., 2019). It is through the interpersonal dimension that difficulties in personal identity, emotion regulation, and the experience of relationships are heightened (Nieuwenhove & Meganck, 2019). The mechanisms underpinning these processes remain unclear, although attachment theory provides a helpful lens for understanding how early caregiving relationships shape self-identity, emotion regulation, and interpersonal functioning (Bowlby, 1988). Traumatic experiences within caregiving or interpersonal relationships often result in insecure or

disorganised attachment patterns, which are associated with difficulties in emotion regulation and relational functioning (Lyons-Ruth et al., 2006). Trauma occurring within trusted relationships often leads to profound challenges in trust, intimacy, and the capacity to sustain personal and community relationships (Herman, 1992; van der Kolk, 2005). These relational disruptions heighten vulnerability to further traumatic experiences and may complicate recovery, as the relational processes needed for healing may be experienced as unsafe or threatening (Pearlman & Courtois, 2005).

Challenges of Definition

For many years, there have been challenges in the classification and understanding of complex trauma. Judith Herman (1992) introduced the concept of complex PTSD, distinguishing it from single-incident trauma by highlighting the significant impact of prolonged and interpersonal trauma on identity, emotion regulation, and relationships. Herman positioned complex trauma within broader social and political contexts, emphasising the role of power, oppression, and silencing in influencing individuals' experiences. Alternative classifications of psychological, emotional, and relational difficulties associated with complex trauma led to the development of the term Disorders of Extreme Stress Not Otherwise Specified (DESNOS; Herman; 1992; Pelcovitz et al, 1997; van der Kolk et al., 2005). This term was developed in response to people experiencing complex trauma difficulties receiving diagnoses of borderline personality disorder, without reference to their early experiences of relational abuse and trauma (Herman & van der Kolk, 1987; Linehan, 1993). There is ongoing discourse within the literature regarding the overlap between complex trauma and borderline personality disorder (BPD) (Ford & Courtois, 2014; Powers et al., 2022).

Other researchers proposed terms to describe the pervasive pattern of difficulties and original traumatising events associated with complex trauma, including developmental, interpersonal, betrayal, and childhood trauma (Freyd, 1996; Kliethermes et al., 2014; Terr, 1990; van der Kolk, 2005). These bodies of work contributed significantly to the growth of understanding in the complex trauma field and emphasised the interpersonal dimension as instrumental within the development of difficulties. However, the use of multiple terms has led to disparities in understanding and a fragmentation of the literature, where accessing information is complicated by a wide range of conceptualisations.

More recently, the diagnostic term CPTSD (Complex Post-Traumatic Stress Disorder; Cloitre at al., 2013; World Health Organisation, 2019) has been incorporated into diagnostic frameworks. This term formally indicates that complex trauma-related difficulties originate in interpersonal and repeated traumas and supersede the challenges associated with single-incident trauma, emphasising the pervasive impact of negative self-concept, emotion regulation difficulties, and problems in relationships, in addition to PTSD related challenges (Herman, 1992).

Complex trauma in clinical and research settings

The National Institute for Health and Care Excellence (NICE, 2018) recommends the use of evidence-based interventions in supporting individuals with trauma-related difficulties. However, many of these therapies were originally developed for single-incident trauma and may be less effective for the chronic, relational, and pervasive impacts that characterise complex trauma presentations (Courtois & Ford, 2013). Research has highlighted an inadequate understanding of the occurrence, prevalence, and impact of complex trauma within mental health systems (Bailey & Brown, 2020). Studies indicate that while complex trauma affects between 1–8% of the general population, prevalence may rise to 50% within

mental health services (Maercker et al., 2022). These factors highlight the clinical significance of developing an understanding of complex trauma within mental health services.

Studies have shown that traumatic histories are poorly recognised in people with severe mental health difficulties, which can result in fragmented care and inadequate treatment (Mauritz et al., 2013; Melton et al., 2020). The inconsistencies in classification and reliance on diagnostic systems have historically limited recognition of complex trauma in service users who present challenges within mental health services (Melton et al., 2020), likely contributing to barriers in treatment. Within the NHS, individuals presenting with complex trauma often pose significant challenges due to the breadth of difficulties they experience, including emotional dysregulation, dissociation, identity disturbance, and relational challenges that extend beyond the scope of standard PTSD interventions (Ford & Courtois, 2014). Additionally, individuals with complex trauma experience mistrust in services and therapeutic relationships, potentially undermining access to support (Cloitre et al., 2020). Where there may be crossover between BPD and complex trauma, service users may be offered dialectical behaviour therapy (DBT) interventions. Although DBT has shown efficacy in reducing PTSD related difficulties and comorbid depressive symptoms (Prillinger et al., 2024), it may be insufficient as a sole treatment for complex trauma, which often requires trauma-focused relationally oriented approaches (Courtois & Ford, 2013).

The Power Threat Meaning Framework and Trauma Informed Care

The Power Threat Meaning Framework (PTMF; Johnstone & Boyle, 2018) offers a valuable lens for understanding the relational and emotional challenges associated with complex trauma. Rather than locating problems within individuals, the PTMF highlights how experiences of power and threat, such as abuse, neglect, coercion, emotional harm, or

relational instability, shape the meanings people form about themselves, others, and the world. These meanings are proposed to influence survival responses, leading to heightened sensitivity to threat, difficulties with trust and boundaries, avoidance, and strong needs for safety or closeness in relationships (Johnstone & Boyle, 2018). Behaviours often conceptualised as symptoms within a psychopathology context can be understood as adaptive strategies developed in environments where emotional needs were unmet or inconsistently recognised. The PTMF considers the influence of wider social, cultural, and structural systems on personal experiences of trauma due to the impact of poverty, discrimination, and inequality, aligning with the earlier work of Herman (1992). This perspective is consistent with the foundations of this thesis which is grounded in a non-pathologising approach towards understanding complex trauma.

The development of Trauma-Informed Care within mental health services reinforces principles of safety, trust, collaboration, empowerment, and choice as essential to practice (Office for Health Improvement & Disparities, 2022; Substance Abuse and Mental Health Services Administration, 2014). However, the implementation of systemic change through this approach remains unclear (Emsley et al., 2022). Trauma-informed care within the UK has been characterised by variability, with coherent national strategies developing in Scotland and Wales (Emsley et al., 2022). In England, progress is described as fragmented and inconsistent (Emsley et al., 2022).

There is a growing recognition of the need to adapt mental health services to better identify and respond to the needs of individuals with complex trauma (Melton et al., 2020). Trauma-informed systems of care that validate individuals' experiences, address relational challenges, and provide effective support for the multifaceted difficulties associated with complex trauma are required. Supportive relationships across personal, community, and systemic contexts are recognised as important protective factors that can buffer the long-term

psychological and relational effects of trauma (Charuvastra & Cloitre, 2008). Such relationships may build resilience, provide corrective emotional experiences, and model healthier relational patterns (Howell & Itzkowitz, 2016).

Therapeutic interventions and complex trauma

Herman (1992) highlighted that therapeutic approaches for complex trauma should prioritise relational healing, emphasising trust and safety as central to recovery. This framework was further developed by Pearlman and Courtois (2005), who integrated attachment theory and research on complex trauma into clinical practice. They proposed that personal and relational difficulties arising from experiences of interpersonal abuse and mistreatment should be addressed within therapeutic relationships. Ford and Courtois (2020) further proposed a sequenced, relationship-based approach, within which the therapeutic relationship serves as a secure base for processing trauma and developing healthier relational patterns. These contributions highlight the importance of relational dynamics in trauma therapy. However, complex trauma is challenging to work with therapeutically, due to countertransference, dissociation, and boundary issues, as well as variability in clinician training and experience (Kumar et al., 2022; Pearlman & Courtois, 2005; Steele & van der Hart, 2009).

The research

There remains a gap within research that directly engages with the voices of individuals who experience complex trauma difficulties (Melton et al., 2020), and the experiences of relationships for people with complex trauma are underrepresented in the qualitative literature. Exploring firsthand accounts of how complex trauma shapes relationships creates opportunities for learning, training, therapy, supervision, and policy development within mental health services. Most importantly, highlighting the voices of

individuals with complex trauma difficulties ensures that mental health professionals are equipped with appropriate knowledge and skills to provide effective and attuned support.

This thesis explores the relationships of adults who experience complex trauma difficulties due to experiences of interpersonal mistreatment, usually originating in childhood. Firstly, this is explored through a qualitative systematic review of the literature relating to the qualities of the therapeutic relationship from the perspectives of individuals with complex childhood trauma and therapists working with this population. A narrative synthesis was used to synthesise the views of clients and therapists on the qualities in therapeutic relationships. This will be followed by an empirical study of the experiences of individuals in their personal relationships as impacted by complex trauma. In the empirical paper, Interpretive Phenomenological Analysis (Smith et al., 2021) formed the methodology and analytic approach to ensure that participants' experiences, meanings, and perspectives were explored in depth. Additional methods will be presented in Chapter 5. Finally, the thesis will conclude with a critical discussion of the research processes and findings.

Chapter 2: Systematic Review

Chapter 2

The therapeutic relationship in therapy with individuals with histories of complex childhood trauma: A Systematic Review

Caroline Mangham, Lawrence Howells & Paul Fisher

Norwich Medical School, University of East Anglia, Norwich, NR4 7TJ, UK

Corresponding author: Caroline Mangham (email: caroline.mangham@uea.ac.uk)

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Abstract

Individuals who have experienced complex childhood trauma encounter particular challenges in therapeutic relationships due to the considerable impacts imposed by their experiences in interpersonal/caregiving relationships. Such difficulties often create challenges in establishing safety and trust, which can lead to therapeutic ruptures and unhelpful therapeutic processes. This review aimed to understand the qualities of the therapeutic relationship within therapeutic dyads in talking therapies through investigating the views of clients with complex childhood trauma-related difficulties and therapists working in this area. The review used a narrative synthesis approach to synthesise data from 12 qualitative studies on the qualities within therapeutic relationships with complex childhood trauma populations. Studies were included from searching four academic databases: Academic Search Ultimate, PsychINFO, MEDLINE Ultimate, and CINAHL Ultimate. The quality of included papers was assessed using the Critical Appraisal Skills Programme (CASP, 2024). Six themes narratively synthesised the findings of the studies: 'The core foundations are fundamental', 'From chaos to coherence', 'Therapists with courage', 'We are in this together', 'Boundaries', and 'A new attachment relationship'. The findings highlighted that the therapeutic relationship emerges as a reparative experience, providing opportunities for individuals with complex childhood trauma histories to rebuild trust, make sense of their difficulties, and form healthier relational patterns. The review emphasised the central importance of safety, trust, relational depth, and attachment as the foundations of meaningful change in therapy for individuals with complex childhood trauma. It also found that without these qualities, ruptures and barriers within the therapeutic relationship were more likely.

Keywords: complex trauma; complex ptsd; childhood trauma; narrative synthesis; systematic review; therapeutic alliance; therapeutic relationship

Background

There is a wide body of research exploring the impact of complex childhood trauma on an individual's quality of life, wellbeing, and relationships (Copley, 2023; Walker, 2013). Experiencing sexual, physical, and emotional abuse in childhood, within the context of caregiving/interpersonal relationships, can lead to the development of complex trauma difficulties (Herman, 1992; Kliethermes et al., 2014; Nieuwenhove & Meganck, 2019). Such challenges include chronic and severe anxiety and depression, attachment difficulties, substance use, self-esteem issues, symptoms of post-traumatic stress disorder, including flashbacks, reexperiencing, and dissociation, and somatic difficulties (Kendall-Tackett, 2024; McKay et al., 2021). Complex trauma often perpetuates a pervasive pattern of challenges that compound the psychological and emotional sequelae of traumatic reactions associated with single-incident trauma, leading to significant challenges in identity disturbance, emotion regulation, and problems in relationships (Nieuwenhove & Meganck, 2019).

It is well documented that the therapeutic relationship is of fundamental importance in improving outcomes for people who engage in therapy, regardless of their presenting difficulties (Norcross & Lambert, 2018). Helpful aspects of the therapeutic relationship have been reported across studies, including enhanced empathy (Elliott et al., 2018), consistency, fostering a sense of safety and collaboration (Iversen et al., 2025), and person-centred practices (Raskin & Rogers, 2005). Particular challenges arise in therapeutic processes and relationships for individuals with complex childhood trauma difficulties, where the nature of their trauma is firmly rooted within caregiving and interpersonal relationships (Ford & Courtois, 2020). For example, in their qualitative study, Iversen et al. (2025) found that individuals with complex trauma difficulties experience fear of rejection linked to previous betrayals, institutional barriers, and fragmented care, leading to challenges in sustaining therapeutic relationships. Additionally, emotional dysregulation and trauma-related

interpersonal patterns and defences can be triggered within therapeutic relationships (Duckworth & Follette, 2011; Tummala-Narra et al., 2011). This can lead to challenges for therapists supporting clients and barriers for clients to experience a sense of safety with therapists (Nieuwenhove & Meganck, 2020; Pearlman & Saakvitne, 1995). It is reported that many clients with complex childhood trauma unconsciously expect therapists to disappoint or harm them, even when they behave appropriately, because of their previous experiences of interpersonal harm (Nieuwenhove & Meganck, 2020). At the core of this relationship is the role of the therapist adopting a caring position in the clients' mental health treatment. However, the interaction of closeness within the alliance, in the context of complex childhood trauma, may create further challenges in the development of a safe and effective therapeutic relationship (American Psychological Association, 2024).

Ford & Courtois (2020) highlight the importance of tailored and trauma-informed therapy for individuals with complex trauma difficulties, emphasising the need for stage-based, relational approaches to treatment. This is considered fundamental where trust and safety in caring relationships have been compromised through experiences of abuse and mistreatment associated with complex childhood trauma. Such recommendations may be impeded by the widespread development of timely and structured evidence-based therapies, and at present, the implementation and effectiveness of stage-based relational approaches remains unclear (Melton et al., 2020). Additionally, there are limitations imposed by service-related factors. For example, through service-driven allocation to structured and timely interventions (NICE, 2018). Limitations may also relate to the knowledge and skills across therapeutic professionals regarding appropriate support for the complex needs of service users in therapy, and fears associated with supporting clients effectively (Pearlman & Saakvitne, 1995). Therapists likely need to manage strong feelings/projections and possess the ability to sit with the distressing narratives and experiences that clients express (Gelso,

2019). Short-term structured therapies may provide supportive and containing frameworks for therapists working with individuals with complex childhood trauma. However, heavily structured approaches may reduce opportunities to develop meaningful and rich relationships in therapeutic processes (Ford & Courtois, 2020). A flexible and nuanced approach within the therapeutic relationship is recommended (Herman, 1992). The nature of the therapeutic relationship has been considered fundamental in supporting individuals with complex childhood trauma difficulties in therapy (Ford & Courtois, 2020; Herman, 1992).

Studies have investigated the therapeutic relationship for supporting clients who have complex childhood trauma difficulties using quantitative (Harrington et al., 2021; Lawson et al., 2020) and qualitative methods. This review seeks to understand the qualities of the therapeutic relationship from the perspective of individuals with histories of complex childhood trauma and therapists using a qualitative approach. This is because the goal of the review is to deeply understand experiences, meanings, and processes, which are well-suited to qualitative investigation (Noyes et al., 2013) and are unlikely to be fully captured through quantitative measurement. Qualitative approaches allow for the exploration of nuance and complexity relating to social, cultural, and relational factors, preserving the richness of lived experience and grounding theoretical and empirical information within a more personal context. This is an important approach for understanding the therapeutic relationship in complex childhood trauma, where the nature of the difficulties are complex, and relationships themselves are nuanced and multifaceted.

Aims

The main aim of the review was to investigate the views of clients with histories and difficulties relating to complex childhood trauma and therapists working in this area, to gain a

comprehensive understanding of the qualities of the therapeutic relationship within therapeutic dyads in talking therapies for complex childhood trauma.

Question

What qualities are associated with the therapeutic relationship in therapy with people who have experienced complex childhood trauma from the perspectives of service users and therapists?

Method

Pre-Registration

The research incorporated the PRISMA updated guidelines for reporting systematic reviews (Page et al., 2021). The study protocol was registered with Prospero on 10th July 2024. Academic databases searches were conducted on 6th June 2025.

Review Question

The review question was developed in accordance with the SPIDER criteria (Sample, Phenomenon of Interest, Design, Evaluation, Research type; Cooke et al., 2012). The SPIDER framework was selected due to its suitability for qualitative research. It is regarded as an alternative to PICO (Population, Intervention, Comparison, Outcome; Richardson et al., 1995), which is usually rooted in clinical trials and quantitative outcomes. SPIDER was specifically designed to capture subjective experiences and meanings, allowing for the inclusion of diverse qualitative methods. This maintains the focus of the synthesis on qualitative data. which aligns with the methodology of the current study. The SPIDER criteria supported the development of search terms, which helped to identify relevant studies yielding qualitative data (Table 1).

Table 1.

Key elements of the review question using the SPIDER criteria

Criteria	Description
Sample	Adult clients or therapists engaging in (either currently or retrospectively) therapy for psychological difficulties relating to complex childhood trauma
Phenomenon of Interest	The therapeutic relationship
Design	Interviews/Surveys/Focus Groups
Evaluation	Experiences and perspectives of participants to determine qualities in the relationship
Research type	Qualitative or mixed methods (where only qualitative data is included in the review)

Eligibility

Studies were included that explored the qualitative accounts of service users' and/or therapists' experiences of the therapeutic relationship. Therapeutic relationships related to client/therapist dyads in individual talking therapy, addressing mental health difficulties in individuals with histories of complex childhood trauma. Articles were required to be based on primary research for review and synthesis. Studies incorporated any qualitative

epistemological frameworks within their analyses and any qualitative data collection technique. Qualitative case studies were excluded because of a potential lack of methodological consistency and comparability across studies. This was assessed through examination of the methodological processes used in the case studies that emerged in earlier searches. There would have been a risk of introducing anecdotal evidence that did not align with the broader aim of the systematic review. This was particularly relevant given the recruitment differences across case studies. For example, therapists reporting on their own cases and narrative reflective reports. Additionally, some case studies were conducted without reference to a specific research method. Such factors may have compromised the synthesis when attempting to identify patterns and themes across multiple participants and contexts, therefore influencing the generalisability of findings and compromising the rigour of systematic synthesis (Carroll et al., 2012).

Search Strategy

Peer-reviewed research articles were searched for in the following databases: Academic Search Ultimate, PsychINFO, MEDLINE Ultimate, and CINAHL Ultimate. The search terms were developed through manual searches in Google Scholar and the UEA EBSCO Database to identify keywords and articles. Two concepts were used to delineate the search terms relating to 1. Complex trauma, and 2. Therapeutic Relationships (Table 2). Titles, Abstracts, and Keywords/Subjects were searched for both concepts across all databases. Boolean operators and truncations were used where appropriate. Other filters or restrictions were not included in the search, and no time restrictions were applied in the search and selection processes. Only peer-reviewed articles were included in the review.

Table 2.

Search terms

Concept	Search Terms
Complex trauma	#1: 'complex trauma' OR complex ptsd' OR 'CPTSD', OR 'childhood trauma' OR 'chronic trauma' OR 'histor* of abuse' OR ' relation* trauma' OR 'interpersonal trauma' OR 'attachment trauma'
Therapeutic Relationship	#2: 'therap* alliance', OR 'therapeutic relationship', OR 'helping relationship', OR 'helping alliance', OR working alliance, OR 'attunement'
Final search strategy	#1 AND #2

Selection Criteria

Inclusion and exclusion criteria are presented in Table 3.

Table 3.

Inclusion and Exclusion Criteria

Inclusion criteria	Exclusion criteria
Studies yielding qualitative data (Qualitative and mixed methods) to be included.	Review articles
Studies must include qualitative data that relates to talking therapy for individuals with histories of complex childhood trauma and abuse.	Books
Involving perspectives/experiences of service users and therapists where therapy has taken place in therapeutic dyads.	Quantitative studies
Research should relate to therapy and contain information which directly discusses the therapeutic relationship.	Group therapy studies
Published in a peer-reviewed journal.	Case studies/reports
No time restrictions on relevant studies.	

	Studies that relate to dance, yoga, music, hypnotherapy, touch-based, and alternative therapies
	Grey literature, including unpublished theses

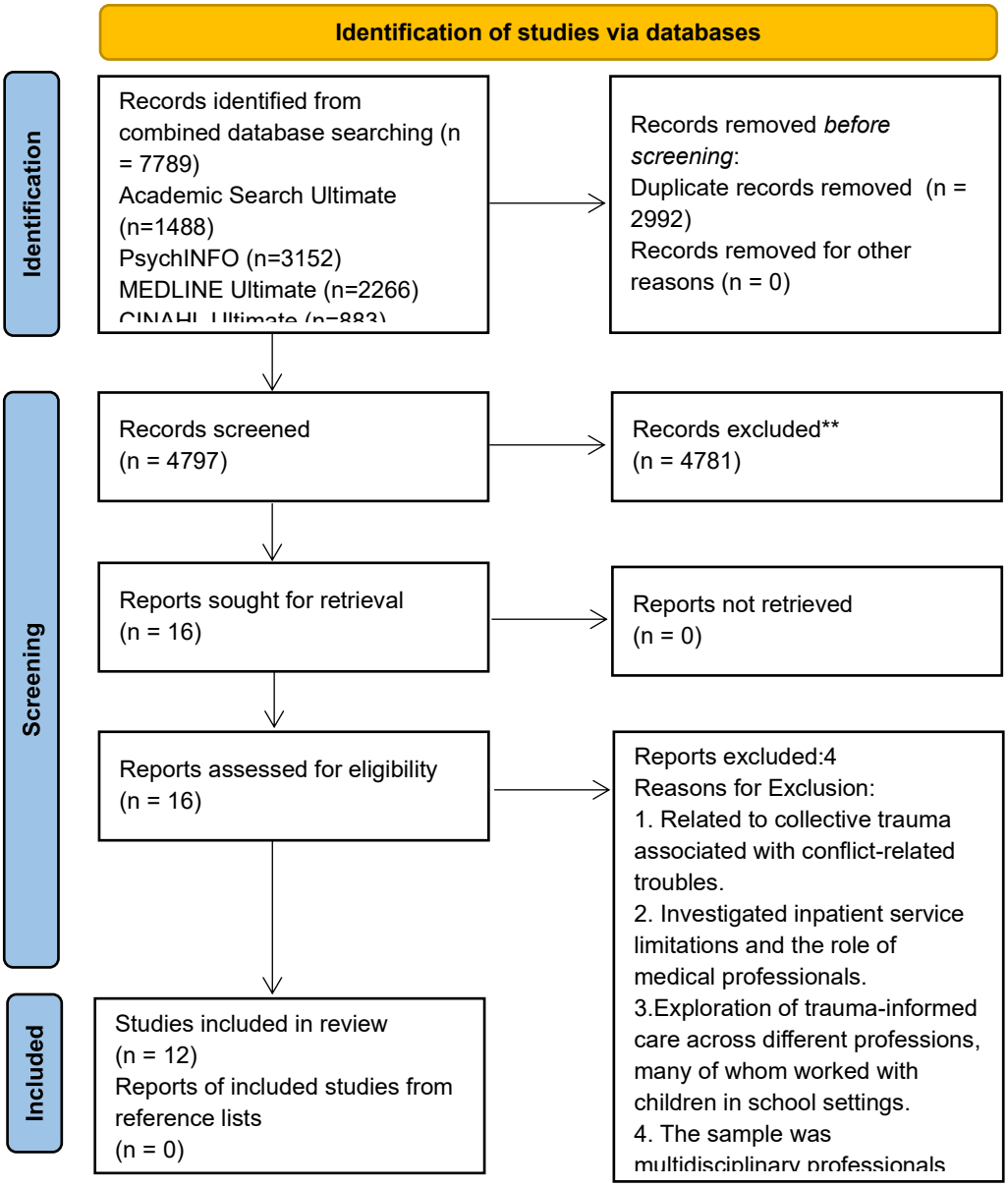
Study Selection

The academic database search results were exported into Endnote and combined to yield a total of 7789 journal articles (Figure 1). Duplicates were removed, leaving 4797 articles for initial screening using Title and Abstract. The initial screening process led to the exclusion of 4781 articles using the inclusion and exclusion criteria. Full text screening was carried out on 16 studies.

The remaining 16 articles were reviewed in full to determine their eligibility. A second reviewer from outside of the research team, with no prior involvement in the study, assessed four of the full-text articles (25%). Any discrepancies at each stage were resolved through discussion to reach a consensus between reviewers. This process resulted in a final selection of 12 studies (Figure 1). Reference lists of selected studies were searched for relevant literature, and this process yielded no further studies that met the inclusion and exclusion criteria.

Figure 1.

PRISMA Flow Diagram



Data Extraction

The researcher extracted relevant data, including participant demographics, methods of data collection, trauma type, analytical approaches, therapy type, quality ratings, and key findings derived from both participant quotations and the researchers' interpretations and commentary

Critical Appraisal

Data were extracted from all 12 included articles, with extraction categories informed by established systematic review guidelines (Cherry et al., 2017; Fleeman & Dundar, 2017). In mixed-methods studies, only qualitative data were considered. The Critical Appraisal Skills Programme Qualitative Checklist (CASP, 2024) was employed to assess the methodological quality of the qualitative studies (Table 4). The CASP is a widely recognised critical appraisal framework. It was selected due its development for use in qualitative systematic reviews and is well established in previous research. The CASP's capacity for encouraging reflexivity on methodological quality, researcher positionality, ethical considerations, and findings was considered advantageous in this review and led to its selection over other tools such as the Joanna Briggs Institute Critical Appraisal Checklist for Qualitative Research (JBI, 2017), to enhance understanding of depth and meaning within the data. Each article was critically appraised using the CASP prompt questions to evaluate whether the criteria for each item were met. This process was carried out by the primary researcher and secondary reviewer. Any discrepancies were discussed and resolved. Following appraisal, the studies were scored based on their assessed quality. Consistent with approaches used in previous reviews (Hendry et al., 2017; McCann et al., 2016), a scoring framework was applied to assess each CASP criterion, allocating 2 points for a comprehensive response (Yes), 1 point for a partial response (Can't Tell), and 0 points for No or insufficient information**.** An overall quality score was then derived for each study, with scores of 17 or above classified as high quality, 11–16 as moderate quality, and below 11 as low quality**.** This weighting process informed the narrative synthesis to ensure that methodological quality was clearly reported. Key findings across papers that reflected depth and meaning in the data were appropriately documented with consideration to methodological quality.

Data Synthesis

A qualitative narrative synthesis was conducted to systematically integrate and interpret findings across the included studies. This approach was guided by the framework developed by Popay et al. (2006). Narrative synthesis allowed for the preservation of the richness and complexity of qualitative accounts from studies, telling the story of the research, and reporting convergence and divergence in the data.

The synthesis involved an iterative process of familiarisation with the data through reading articles several times. Particular attention was given to the method, results, and discussion sections. Following extraction of the key findings and study characteristics, notes and inferences were made on the results and discussion sections for each study. Notes, inferences, and quotes were recorded in a Microsoft Word document. Once each article had been reviewed in full, the data from the results and discussion sections for each study was coded and themes were developed. This process was guided through the co-construction of theme development with the research team. A narrative was formed that captured both the commonalities and variations across studies, with reference to methodological characteristics and rigour across studies. This method allowed for the preservation of contextual richness while identifying overarching themes relevant to the therapeutic relationship in treatment with people with complex childhood trauma difficulties.

Results

Study Characteristics

The characteristics of the included studies are presented in Table 5. Studies were conducted across five countries: UK (n=4), USA (n=2), Australia (n=1), Canada (n=1), New Zealand (n=1), Sweden (n=1), Israel (n=1), and The Netherlands (n=1). There was a total of 238 client participants across the studies. However, Middle & Kennerley (2001) interviewed

17 participants who had not experienced childhood sexual abuse (CSA) to make a comparison against the CSA group relating to experiences of the therapeutic relationship. Some of these findings are represented in the review. There was a total of 110 therapist participants in the review, plus three key informants in the study carried out by Chouliara et al. (2024). Efforts were made not to include the views of key informants, as they were not therapeutic professionals and their views were not relevant to the research question. Most of the studies used interviews to collect qualitative data in the following formats: semi-structured (n=6), qualitative (n=2), and interview (n=2). Focus groups and a dyadic interview were also employed (n=1) and questionnaires (n=1). Interpretive Phenomenological Analysis was the most frequent method of analysis employed (n=4), followed by Thematic Analysis (n=3), Grounded Theory (n=2), Holistic Content Analysis (n=1), and Narrative Content Analysis (n=1). Dalenberg (2004) did not report the analytic method used in the study.

Quality Appraisal

Six studies were rated as high in quality, and five studies were rated as moderate. One paper was classified as low quality. Quality ratings for all included studies are presented in Table 5. All papers, excluding the study by Dalenberg (2004), clearly stated their research aims. All studies employed an appropriate qualitative methodology. However, more than half did not address the researcher–participant relationship (n = 7), and a further three provided only limited information on this issue. Only two studies (McGregor et al., 2006; van Berkel et al., 2025) engaged with this aspect in sufficient depth. The majority of studies clearly reported their findings (n = 11) and over half (n = 8) discussed the wider value and applicability of the research.

Table 4. *Study Characteristics*

Author/Year of publication/ Country	Participants	Age range	Gender	Type of abuse/trauma	Type of therapy	Data collection method	Analytic method	Main findings
Beaton & Thielking, (2019), Australia	10 psychologists	32-65	4 males, 6 females	Psychologists in practice with young women aged 18–25 with complex trauma and a history of childhood maltreatment.	Not reported	Semi-structured interviews	TA	Trust was considered essential for engaging young women with complex trauma; therapy was often hindered by clients' deep-rooted mistrust stemming from childhood maltreatment. Two key themes underscored the central role of trust: psychologists must build trust with young women who have experienced complex trauma and childhood maltreatment, and trust within their intra- and interpersonal relationships, developed through therapy, is foundational for healing. Four subthemes emphasised that: (1) distrust is a pervasive issue for this group; (2) therapy cannot progress without initial trust; (3) a mutually trusting therapeutic relationship is essential; and (4) trust takes time to develop.
Chouliara et al., (2011),	13 service users,	Service users	13 female service users,	13 survivors of Childhood Sexual Abuse	CBT 12 Person-centered 14	Qualitative interviews	IPA	Survivors and professionals highlighted both benefits (e.g., trust, safety, reduced isolation)

United Kingdom	31 psychotherapists	18+ years	6 male and 21 female psychotherapists (4 not reported)	and 31 professionals working in the field of Childhood Sexual Abuse	Art therapy 1 CAT 2 CMT 1 DBT 3 interface intervention model 1 SFT 1 Majority: eclectic approaches			and challenges (e.g., access, stigma) of talking therapy for CSA recovery. The study identified two main themes from survivors' and professionals' perspectives on the benefits and challenges of talking therapy. Reported benefits included building a trusting therapeutic relationship, feeling safe to disclose abuse, reducing isolation, improving self-esteem and identity, contextualising the abuse to reduce stigma, and progressing toward recovery.
Chouliara et al., (2024), United Kingdom	10 therapeutic clinicians and 3 key informants	30-61	2 males, 11 females	Complex trauma (child sexual abuse, domestic/intimate partner abuse, rape, assault	CBT 5 Person-centered 4 Psychodynamic 3 Systemic 2 Integrative 7	Qualitative interviews	IPA	The study findings position trust as the essential foundation of the therapeutic relationship, process, and change, in the context of complex trauma. Trust was understood as the central therapeutic goal - a multilayered relational experience that underpins healing. Findings challenged prior models that framed the therapeutic relationship as merely an alliance or collaborative dialogue. The study used the findings to create a Person-centred

								conceptualisation of therapeutic trust in complex trauma.
Dalenberg (2004), United States of America	132 Adults who had completed long term trauma therapies	Not reported	38 males, 94 females	52% of sample relating to childhood abuse	Cognitive behavioral 34% Analytic 53% Humanistic 13%	Interviews	Not described but quotes are reported	Anger and mistrust were found to be common in trauma therapy. Clients reported being angry at therapists, and experienced therapist anger as unjust. Therapist's emotional disclosure was associated with higher client satisfaction and better outcomes; nondisclosure often led to ruptures in the therapeutic alliance. Common triggers of client anger included therapist interpretation, disbelief/minimisation, boundary shifts, and perceived manipulation. Helpful therapist responses included open discussion of emotions, taking partial responsibility, and modelling self-analysis. Nonresponse or hostile disclosure was perceived poorly. The ability to tolerate and process anger within a therapeutic relationship was linked to positive outcomes.
Hirikata, (2009), Canada	7 adults with a history of childhood	34-53	1 male, 6 females	Childhood sexual abuse and	Not reported	Semi-structured interviews	HCA	Effective treatment involved grounding, validation, and building trust over time.

	sexual abuse and current dissociative behaviour			dissociative behaviour				Three major themes and related subthemes emerged: (a) the use of specific tools and techniques deemed essential for managing dissociative difficulties; (b) a critique of the dominant medical model, emphasising the need to help clients normalise and contextualise dissociation; and (c) the importance of therapeutic relationship qualities, such as trust and safety, that support healing and integration.
McGregor et al., (2006), New Zealand	20 participants who had previously attended therapy	26-57	20 females	Childhood sexual abuse	Not reported	Semi-structured interviews	GT	Women identified helpful therapy as involving empathy, validation, and trust-building; unhelpful therapy often lacked attunement or retraumatised clients. The study identified three key areas: (1) building a therapeutic relationship, (2) discussing the experiences and impacts of CSA, and (3) addressing therapeutic errors. Findings suggested that to prevent serious missteps, therapists must possess specialised skills to navigate CSA-related dynamics and content, and build an open, collaborative relationship that includes regular feedback from

								clients about their therapy experience.
Middle & Kennerley, (2001), United Kingdom	34 participants: 17 in the CSA group and 17 in the non-CSA group	21-63 years	34 females	Childhood sexual abuse (in the CSA group)	The majority of the therapists were cognitive-behavioural therapists	Semi-structured interviews	GT	CSA survivors valued therapists who were consistent, non-judgmental, and emotionally present; trust was harder to establish than with non-abused clients. The analysis revealed that both groups identified similar key factors related to the therapist, the therapy process, and the client's perception of the relationship. However, women in the CSA group placed greater emphasis on the therapist's interpersonal qualities and the emotional tone of the relationship while non-CSA clients focused more on techniques and therapeutic progress. Unique concerns among the CSA group included the therapist's commitment, being believed, and the importance of non-judgmental responses.
Midgow, (2011), United States of America	15 patients and 15 therapists	Patients: 25-70 Therapists: 32-75	Patients: 3 males, 12 females Therapists: 2 males,	Childhood chronic abuse and neglect	Psychotherapy	Interviews	NCA	This research indicated that trauma survivors' experience of pleasure was threatening and emphasised that therapy must address shame and bodily dissociation to support healing.

			13 females					Specific to the therapeutic relationship, in many therapist-client pairs, both described meaningful therapeutic moments when the therapist stepped outside their usual clinical role. Across the sample, qualities such as safety, consistency, reliability, predictability, and compassionate care were consistently highlighted as key to creating a positive and reparative therapeutic relationship. Two relevant themes were identified: out of frame and therapeutic repair
Sandberg et al., (2017), Sweden	5 patients/ former patients	26-50	2 males, 3 females	Complex trauma relating to childhood experiences of abuse and neglect	Psychodynamic EMDR CBT	Semi-structured interviews	TA	Patients/former patients described corrective emotional experiences in therapy as central to healing; trust, empathy, and therapist authenticity were key. Four themes emerged: Human contact, Validation, Facing the painful, and Development of trust. Positive therapeutic relationships were often seen as vital to the healing process. The findings reinforced the importance of corrective emotional experiences, particularly the therapist's accepting attitude, genuine

								human connection, and encouragement. The ability to build trust and support clients in confronting painful material was especially significant for trauma survivors.
Toporek et al, (2025), Israel	12 relational therapists	32-77	3 males, 9 females	Treating a wide range of traumatic events with a particular focus on sexual abuse, childhood traumas, and interpersonal traumas.	Relational therapy	Semi structured interviews	IPA	Therapists reported a dialectical process of empathy and balancing emotional attunement with professional boundaries when treating trauma. Findings highlighted empathy as a double-edged sword: a dialectical process that simultaneously involves the emotional toll of caring and the potential for resilience and personal growth. The findings present a nuanced perspective on trauma therapy, suggesting that while compassion fatigue may be an inevitable part of the therapeutic journey, it also contributes to the processes of healing and development. Empathy encompassed both connection and emotional distance.
Van Berkel et al., (2025), The Netherlands	12 participants who had previously	20 + years old	1 male and 11 females	Childhood sibling sexual abuse	Not reported	Focus groups and one dyadic interview	TA	Survivors emphasised the need for therapists to listen without judgment; trust and validation were crucial for feeling safe

	completed therapy due to experiences of childhood sibling sexual abuse							and understood. Three core themes and related subthemes were developed: (1) many survivors of sibling sexual abuse (SSA) face significant challenges in disclosing their experiences and fully engaging in the therapeutic process. (2) SSA often occurs within the family context and disrupts multiple family relationships, highlighting the need for therapy to address broader relational dynamics. (3) Establishing trust and validating the client's narrative are essential for creating a secure therapeutic environment. Additionally, therapists should recognise and build upon clients' strengths and therapeutic approaches should be tailored to each client's needs and stage in their recovery journey.
Yarrow & Churchill, (2009), United Kingdom	32 counsellors and psychologists working in an NHS Trust Department	20-59	7 males, 22 females, 3 unknown gender	26 had worked with male survivors of child sexual abuse	Not reported	Questionnaire	IPA	Therapists noted that male survivors often struggled with shame and disclosure; building trust and addressing gendered expectations were essential. Participants expressed empathy, respect, emotional containment, and genuine concern for clients within this

			population. A prominent theme that emerged was the significance of the therapist's gender, often accompanied by feelings of anxiety or uncertainty. Additional themes included the centrality of the therapeutic relationship, dynamics of transference and countertransference, professional challenges, perceptions of no gender-related differences, and reflections on the clients' presenting issues.

Note: IPA=Interpretive Phenomenological Analysis; TA=Thematic Analysis; GT=Grounded Theory; NCA=Narrative Content Analysis; HCA=Holistic Content Approach

Table 5.

Summary of Critical Appraisal Using the Qualitative Critical Appraisal Skills Programme Checklist (CASP, 2024)

	Section A: Are the results valid?						Section B: What are the results?			Section C: Will the results help locally?	
Paper, number, author and year	Was there a clear statement of the aims of the research?	Is a qualitative methodology appropriate?	Was the research design appropriate to address the aims of the research?	Was the recruitment strategy appropriate to the aims of the research?	Was the data collected in a way that addressed the research issue?	Has the relationship between researcher and participants been adequately considered?	Have ethical issues been taken into consideration?	Was the data analysis sufficiently rigorous?	Is there a clear statement of findings?	How valuable is the research?	Quality rating
1, (Beaton & Thielking, 2019)	2	2	2	2	2	1	2	2	2	1	18
2, (Chouliara et al., 2011)	2	2	2	2	1	1	1	2	2	2	17
3, (Chouliara et al., 2024)	2	2	2	2	2	0	1	2	2	2	17

4, (Dalenberg, 2004)	1	2	1	2	1	0	0	1	1	1	10
5, (Hirikata, 2009)	2	2	2	2	1	0	2	1	2	1	15
6, (McGregor et al., 2006)	2	2	2	2	2	2	1	2	2	2	19
7, (Middle & Kennerley, 2001)	2	2	1	1	1	0	2	1	2	2	14
8, (Midgow, 2011)	2	2	1	2	1	0	0	2	2	0	15
9, (Sandberg et al., 2017)	2	2	1	2	2	1	1	2	2	2	17
10, (Toporek et al., 2025)	2	2	2	2	2	0	1	1	2	2	16
11, (van Berkel et al., 2025)	2	2	2	2	2	2	2	2	2	2	20

12, (Yarrow & Churchill, 2009)	2	2	1	1	1	0	1	1	2	2	13

Note: 2=Yes; 1=Can't Tell; 0=No

Narrative Synthesis

This section presents the findings from the included studies, synthesised narratively to explore patterns, themes, and variations. Six themes were developed and co-constructed collaboratively with the research team: 'The core foundations are fundamental', 'From chaos to coherence', 'Therapists with courage', 'We are in this together', 'Boundaries', and 'A new attachment relationship'. Findings are described in relation to study characteristics, with supporting excerpts and attention to convergence and divergence in the evidence.

Theme 1: The core foundations are fundamental

This theme explores recurring findings within the studies relating to the fundamentals of the therapeutic relationship, including safety, trust, attunement, active listening, empathy, and genuineness. Many studies drew upon the core aspects of the relationship as the key ingredient of the work:*"…therapeutic relationship… creating a safe of acceptance, trust, and rapport with the client… even if there's nothing else in terms of interventions but you're an adult… that's interested, that's listening… a safe place to explore and process",* (Beaton & Thielking, 2019, p 237). Their study related to a specific sample in terms of age and gender. However, this finding was corroborated by Migdow (2011) who investigated the challenges in experiencing pleasure for people with histories of complex childhood trauma: *"safety, compassionate, caring, reliability, and predictability were named throughout the sample as necessary elements of a pleasurable, reparative therapeutic relationship"*, (Migdow, 2011, p 560). These aspects seemed to create the necessary conditions for trust to develop, forming a foundation of safety due to the capacity of the therapist to attune to the clients' needs. Without the fundamental conditions of trust, safety, and acceptance within the relationship, there was a risk of rupture or abrupt endings of therapy.

Human traits of the therapist were emphasised, such as the importance of kindness, care, presence, and compassion in developing trust. Chouliara et al. (2024) highlighted the presence of the therapist as fundamental to the work: *"…paying attention is hugely healing, hugely therapeutic. 'I'm paying attention to you… I am there to bear witness to what happened to you… The other thing that struck me… was that trust was kindness"*, (Chouliara et al., 2024, p 188). In another study, the authenticity of the therapist was highlighted by participants who experienced dissociation related to childhood sexual abuse as vital to the therapeutic relationship: *"My therapist is genuine in our relationship, and I think that's critical because survivors of trauma know. We know how to recognise whether a person is being real or not, and she needed to be genuine with me in order to be successful",* (Hirikata, 2009, p 307).

A lack of attunement and insufficient caring responses were reported as destructive to the therapeutic relationship by McGregor et al. (2006) who interviewed women with histories of childhood sexual abuse about their experiences in therapy. The participant expressed a lack of trust with the therapist due to a lack of response: *"She was totally passive… every now and then I'd say to her 'I'm finding this really difficult'… she'd sit there and no response",* (McGregor et al., 2006, p 52). Similarly, Dalenberg (2004) reported that therapist disbelief or minimisation was experienced as a betrayal by participants in their study investigating anger in complex trauma: *"He never believed me that I remembered last session as well as he did. If we remembered it differently, I was always wrong",* (Dalenberg, 2004, p 442).

Theme 2: From chaos to coherence

This theme relates to findings from studies that indicated therapists supporting clients through understanding, validating and reframing their traumatic difficulties as an

understandable response to complex childhood trauma experiences were beneficial to therapeutic relationships and clients' self-understanding and growth. This process also deepened trust within the therapeutic relationship.

Sandberg et al. (2017) investigated significant and corrective experiences in the therapeutic relationship for clients with complex childhood trauma: *"… that she said… 'It is evident that it influences you' and 'Of course you may be stuck in those thoughts…'. First I got very sad. I had waited twenty years to come to this point. Imagine if someone had said this to me when I was fifteen",* (Sandberg et al., 2017, p 187). This finding demonstrated that therapists understanding and validating the effects of trauma can give rise to significant shifts in self-understanding for clients in the context of a safe and attuned therapeutic relationship. The authors primarily focussed on reparative experiences, which may have yielded more positive narratives from participants. It was important for participants in Hirikata's (2009) study that therapists convey a sense of understanding and validation through reframing the effects of mistreatment and abuse, to counter negative self-beliefs and dissociation, which resulted from experiences in traumatic relationships: *"I often wonder if I'm crazy… because none of this makes sense… my memory… my life… It's very important for therapists to convey that you are not crazy, that this is natural, and that we are not stupid"*, (Hirikata, 2009, p 304). Hirikata's (2009) study focussed primarily on treatment experiences of people who suffered with dissociation related to childhood sexual abuse.

Clients in the study by Migdow (2011) similarly felt supported by therapists in making sense of their trauma difficulties within a safe and trusting therapeutic relationship, creating a shift towards self-understanding:

> *"Before I started therapy, I was just surviving. I was dying inside and no one noticed. Having been in therapy for a while, I'm finally getting a grip on why I just thought I was crazy that there were these other parts"*, (Migdow, 2011, p 560).

When therapists fail to validate and understand a client's experience, this can lead to ruptures within the therapeutic relationship and negative emotional consequences for clients: *"I don't think he thought that my dad was that bad. He kept making excuses for him, and it made me mad",* (Dalenberg, 2004, p 442). During quality appraisal, this paper was not rated as strongly as others in the review, yet it contributed valuable insights by highlighting critical perspectives on difficult or negative experiences within therapeutic relationships.

Theme 3: Therapists with courage

Throughout the studies, an important finding relating to the skills and courage of therapists was expressed by both parties within therapeutic dyads. Clients valued therapists who were able to sit with them in dark places, take risks, and express vulnerability, leading to deepened bonds within therapeutic relationships and enhanced trust and safety. Chouliara et al. (2024) found that self-disclosure of the therapist enhanced therapeutic bonds: *"I think in some ways you have to give… a bit of yourself too, because I think, prior to working in this field (trauma), possibly I didn't disclose as much… I disclose a little more.. in a more meaningful way",* (Chouliara et al., 2024, p 190). This finding highlighted that therapists taking risks and disclosing personal vulnerability within therapeutic relationships were considered important in working with people who experienced complex childhood trauma difficulties.

Some studies highlighted the need for therapists to show courage in stepping outside of the usual confines of therapy with clients. This seemed to promote safety within the therapeutic relationship when clients were struggling or in crisis. Participants in Hirikata's

(2009) study expressed that being there and providing support outside of sessions helped to instil trust:

> *"There are times when we felt like a real pain for phoning [our therapist] so often but she would say, "You need to talk so it's okay, and I'm really glad you called." She always makes us feel that we aren't doing anything wrong, and time and time again she proves to us that whenever we need her, she'll be there".* (Hirikata, 2009, p 305).

Responding to clients in a way that seemed 'out of frame' and taking therapeutic risks was highlighted as a theme in Migdow's (2011) paper. Such experiences seem to counter the usual structure of therapy encounters. However, when implemented with a sense of care, the courage of therapists in taking risks was seen to contribute to therapeutic trust in the relationship for clients: *"She showed up in my apartment… to do an intervention. And, it was probably one of the most intensely uncomfortable moments I can remember. And yet, I think it was… also a breakthrough",* (Migdow, 2011, p 559). The authors highlighted how pleasure could be experienced by clients in therapeutic relationships when the therapist prioritised their wellbeing through unconventional means.

Courage also related to therapists being able to ask questions about the abuse. Van Berkel et al. (2025) investigated therapy experiences with individuals who had experienced childhood sexual abuse. They found that some participants felt that therapists would not be able to 'handle their story' and therefore held back distressing details. Participants valued therapists who were able to ask them questions: *"…therapists should not be afraid to discuss the subject…. Several times, because I think that also helps",* (van Berkel et al., 2025, p 6). This finding indicated that therapists being able to sit with clients' pain and distress was fundamental to the therapeutic relationship. Toporek et al. (2025) investigated the 'double-edged sword of empathy' and emotional burden on therapists. Therapists reflected courage in

engaging with deeply painful narratives and an ability to demonstrate authentic empathy: *"Empathy is me having the capacity to perceive, understand, to hold, to contain"*, (Toporek et al., 2025, p 4). Courage within the relationship is important for therapists due to the role they play in the client's life in the context of earlier relational betrayals. For example, Yarrow and Churchill (2009) investigated therapists' experiences of working with male survivors of childhood sexual trauma. A participant noted they had a *"fear of being placed in an abuser role",* (Yarrow & Churchill, 2009, p 273).

Theme 4: We are in this together

This theme relates to the dynamics within the therapeutic relationship as a shared journey through treatment, with an exchange of power at times between client and therapist. Many studies reflected the importance of co-collaboration, conscientiousness, and power as fundamental within the relationship: A therapist in Chouliara et al.'s (2011) study reflected on care and collaboration:

"I always kind of feel like there is this is china ball or something that you are holding between you and it has to be kind of in that we are both holding it together and it has to be held with a lot of care", (Chouliara et al., 2011, p 144).

This finding was similarly expressed by a participant who suffered dissociation as a result of childhood sexual abuse:

> *"It helps because my therapist embodies the fact that this is my journey… I may not be ready to go somewhere but my therapist will radiate a sense of confidence in me that says, 'Okay, when you're ready we'll go there and when we go there we'll go there together'"*, (Hirikata, 2009, p 304).

Promoting self-agency and the client maintaining power in the direction of the therapy was valued in the therapeutic relationship. Middle and Kennerley (2001) explored the

therapeutic relationship in two groups of people – those who had experienced sexual abuse and those without abuse histories. They found that those who had been abused valued being able to follow their own agenda in therapy, enhancing safety and trust in the relationship: *"if I was going to open to the door then I had to do it in my own time"*, (Middle & Kennerley, 2001, p 203).

When the therapeutic relationship lacked equality and co-collaboration, this was problematic for clients. Participants who had experienced childhood sibling sexual abuse felt triggered by therapists who positioned themselves as experts and expected compliance, leading to *"guarding personal boundaries and… not contributing to a client feeling recognised"*, (van Berkel et al., 2025, p 6). Similarly, adhering too closely to protocols without listening to the wishes of the client led to them feeling disempowered in their treatment: *"every time I had to say: I want to work on my trauma, I want to work on my trauma, I want to deal with my trauma. Yes it will come, it will come, it will come",* (van Berkel et al., 2025, p 6). Such findings may infer feelings of reduced confidence or uncertainty on the part of therapists, leading to rigidly adhering to protocols to establish safety or certainty in the therapeutic endeavour, consequently negatively impacting the therapeutic relationship.

Theme 5: Boundaries

This theme relates to findings in studies that reported the importance of boundaries in therapeutic relationships in instilling a continued sense of trust and safety. This was emphasised by Toporek et al. (2025). A relational therapist described the necessity of boundaries in developing trust: *"Very clear boundaries between me and my patients – very very clear, because the relationships are so confusing",* (Toporek et al., 2025, p 5).

Middle and Kennerley (2001) reported that the responsibility of therapists in establishing boundaries was important for participants who had experienced childhood sexual abuse. Such boundaries related to session length, expectations of themselves and therapists, and therapist disclosure. Similarly, therapists working with male survivors of sexual abuse in the study by Yarrow and Churchill (2009) emphasised the importance of being mindful of boundary issues to maintain safety within therapy, where supporting male survivors may have particular considerations for therapeutic boundaries within the relationship.

Longer time frames for therapies were considered helpful for clients with complex childhood trauma. Beaton and Thielking (2019) emphasised the importance of a 'slow-paced and long-term approach' as being ideal. The authors critiqued the system with which they practiced in Australia, which reflected a tension between service provision and therapeutic need. A psychologist from that study reflected: *"... you've got to do it slowly... they need a lot longer to know they've got a trusting relationship with you... the therapeutic relationships... I feel have gone the best... where we've had 12 months to work with each other"*, (Beaton & Thielking, 2019, p 238). All therapist participants in the study by Chouliara et al. (2024) emphasised that going slowly in therapy provided time for clients to test the waters and build up a foundation of trust gradually, leading to deeper engagement in the therapeutic relationship. Similarly, Yarrow and Churchill (2009) found that several therapist participants felt that 'pacing the work' was helpful.

Theme 6: A new attachment relationship

This theme related to the modelling and formation of a healthier attachment relationship within the therapeutic alliance because of the development of trust and safety, leading to therapeutic breakthroughs for clients. Sandberg et al. (2017) explored the value of unconditional trust in the therapist igniting a male participant's awareness of the need for a

secure base: *"So I realised that 'I want this!' Even if it's hard and awful. Even if I don't know and even if I have to go there, that's the way to become a human being… to become whole"*, (Sandberg et al, 2017, p190). The discomfort associated with the development of security within the relationship was similarly reflected by a therapist participant in the study by Midgow (2011):

> *"I think as she and I have fostered our attachment, she's also more anxious and dissociative about being here because she's growing more aware of the comfortable thing we have and that in itself scares her and she needs to put up a wedge"*, (Migdow, 2011, p 558/9).

The uncertainty of developing an attachment relationship within the therapeutic alliance was something new and uncomfortable, but one that was described as fundamental for the progression of therapy.

Modelling of a healthier attachment was described as a novel experience that was fundamental to the development of relationships outside of therapy:

> *"I never had a sense of how to depend on anyone before. None of that stuff was ever modeled for me in my family and . . . and I feel as if I've been re-parented to a certain degree. . . . I use my relationship [with my therapist] as a model for other relationships that I'm in because . . . because in a way, it's like having a surrogate relationship with a person who teaches you how to be in the world"* (Hirikata, 2009, p 306).

The nature of the therapeutic relationship therefore moved beyond the mechanics of therapy, emphasising the importance of the attachment between the therapist and client in supporting clients to form a healthier blueprint for relationships:

"It has felt like a friend in a way. And … it's not an eternal relationship but it was like a mother in some way. It may sound a bit sick to describe it like that, but if you are not used to having that role … So I think it has been very good", (Sandberg et al., 2017, p 185).

Discussion

This systematic review narratively synthesised qualitative studies exploring the qualities associated with the therapeutic relationship in therapy with individuals with complex childhood trauma. It considered the perspectives of both clients and therapists. A narrative synthesis of 12 qualitative studies led to the development of six themes: 'The core foundations are fundamental', 'From chaos to coherence', 'Therapists with courage', 'We are in this together', 'Boundaries', and 'A new attachment relationship'.

Theme one emphasised fundamental conditions within the therapeutic relationship. For individuals who experienced early relational harm, their ability to feel safe with others and to trust in the reliability or authenticity of relationships had been severely compromised. Therefore, trust and safety are deemed essential because trauma survivors often anticipate rejection, abandonment, or harm (Herman, 1992). Safety is considered a core goal of the therapeutic relationship, particularly in the early stages of therapy (Greenberg, 2020). However, it is argued that safety cannot be achieved without trust (Chouliara et al., 2024). The findings of this review, including Middle and Kennerley's (2001) contributions, emphasise that therapists' interpersonal qualities and emotional tone are fundamental for individuals who experience complex childhood trauma, offering insights into the ways that safety and trust develop. The current review indicates that the maintenance of trust and safety within the relationship is imperative throughout the duration of therapy, due to the complexity of individuals' difficulties and the ongoing risk of relational ruptures (McGregor

et al., 2006). Building trust gradually and consistently allows individuals to engage in therapy safely, reducing fears or the likelihood of being retraumatised (Pearlman & Courtois, 2005). Additionally, the review highlights that genuineness, kindness, and care from therapists may counter individuals' past experiences of abuse, mistreatment, or emotional invalidation. While transparency, consistency, and authentic relating provide reparative relational experiences.

Theme two explored therapists understanding, validating, and reframing trauma difficulties as conducive to therapeutic relationships and supportive of clients' self-understanding and growth. Promoting understanding and conveying trauma-based knowledge are important therapeutic processes when working with individuals who have experienced complex childhood trauma (Chouliara et al., 2024; Phoenix, 2007). This is because many survivors interpret their difficulties as signs of personal defectiveness (Herman, 1992), due to internalised beliefs originating from experiences of mistreatment in childhood (van der Kolk, 2014). Supporting clients to develop a sense of coherence through validating and understanding their difficulties within therapeutic relationships helped to reduce shame and self-blame, whilst developing self-compassion, through reframing complex trauma difficulties as understandable and adaptive survival responses (Courtois & Ford, 2013; Gilbert, 2010). It is likely that when individuals understand their struggles as a trauma response, rather than an inherent personal failure, trust and engagement in the therapeutic relationship are enhanced, aiding recovery. The review findings demonstrate the importance of therapists communicating their knowledge of the impacts of complex childhood trauma in therapeutic relationships with clients.

Theme three reflected the shared perspectives of clients and therapists on the necessity for therapists to hold courage within the therapeutic relationship. The review found that self-disclosure was regarded as positive within therapeutic relationships, supporting

similar findings from previous research (Henretty & Levitt, 2010). In therapy with individuals who have experienced complex childhood trauma, appropriate and measured therapist self-disclosure can humanise the therapist, build trust, and model healthy emotional regulation (Pearlman & Saakvitne, 1995). When used thoughtfully, therapist self-disclosure likely strengthens genuineness and relational safety, developing the core foundations in the relationship. However, this is an under-researched area that would benefit from further insight and understanding to ensure safe disclosure practices are adopted in the best interests of clients with complex childhood trauma. Therefore, further research is recommended.

The courage required for therapists to bear witness and contain pain and distress was fundamentally important, considering the complexity of emotions (including anger and fear) that many people with histories of complex childhood experience and express (Dalenberg, 2004; Greenberg, 2020). This element is two-fold. Firstly, therapists should be able to sit 'in the dark' with clients in their most sensitive moments, to build trust within the relationship and provide a sense of continuity which may counter previous experiences of abandonment (Herman, 1992). Secondly, courage is required for therapists to introspect and take responsibility for their missteps in therapy that might impact the relationship in negative ways. Through self-awareness, reflection, and openness with clients, ruptures can be managed in a more conducive way, deepening bonds within the relationship (Gelso & Hayes, 2007; Pearlman & Saakvitne,1995).

Theme four related to equity within the therapeutic relationship, highlighting the importance of power, where clients' needs for leading therapeutic discussions were valued. This is reflected by Brown and Augusta-Scott (2007), who emphasise the importance of recognising individuals' agency and power in telling the stories of their lives. The review findings indicate that equity and attention to power dynamics were central to effective therapeutic relationships with individuals who have experienced complex childhood trauma.

This is especially pertinent as relational trauma frequently involves imbalances of power and violations of autonomy, leading to fears of authority and vulnerabilities towards being controlled or coerced by others in relationships (Herman, 1992). Establishing respectful and equitable relationships in therapy supports clients in developing autonomy, builds safety, and reduces the risk of replicating earlier abusive dynamics (Courtois & Ford, 2013; Pearlman & Saakvitne, 1995). Additionally, when therapists model respectful and reciprocal interactions, they provide opportunities for corrective experiences within the therapeutic relationship, which can support in repairing attachment and relational difficulties that have developed because of complex childhood trauma (Ford & Courtois, 2020).

Theme five reflected the findings across studies that emphasised the importance of boundaries within therapeutic alliances, where containment within the relationship was fundamental. Boundaries have a direct effect on the effectiveness of therapy and require careful consideration within the therapeutic relationship (Zur, 2009). The importance of boundaries and pacing aligns with existing theoretical frameworks in trauma treatment (Courtois & Ford, 2013; Herman, 1992), where establishing safety forms an essential foundation for further therapeutic work. This relates to the first theme, building upon the core foundations and emphasising the importance of safety in characterising the whole therapy process. From an attachment perspective, the clarity and consistency of therapeutic boundaries may help to repair disorganised or insecure attachment patterns, offering clients a corrective relational experience where trust and reliability can be tested and internalised over time (Liotti, 2004). Boundary issues require careful consideration and reflection on the part of the therapist. These elements are highlighted within the review due to the emphasis on the importance of therapists sometimes stepping out of the usual limits of therapeutic encounters and using self-disclosure. The importance of supervision is therefore emphasised in

negotiating therapeutic relationships to ensure ethical practices with complex childhood trauma populations.

The emphasis on slow, client-paced processes reflects therapists' and wider services' needs to recognise and attune to clients' sensitivity to relational threat and mistrust. As Beaton and Thielking (2019) and Chouliara et al. (2024) highlighted, longer-term therapy and careful pacing allow clients to 'test the waters' gradually before risking deeper engagement. These actions likely reinforce the role of the therapeutic relationship as a secure base (Bowlby, 1988). These findings highlight systemic tensions, where service provision may prioritise short-term interventions that may be incompatible with the extended timeframes necessary to build trust and facilitate meaningful change in therapy with individuals with complex childhood trauma.

Theme six emphasised the therapeutic relationship as a corrective attachment experience, in which safety and trust allowed clients to express vulnerability, demonstrate courage, and experience therapeutic breakthroughs. This resonates with attachment theory (Bowlby, 1988), which outlines that the development of a secure base is essential for emotional growth and resilience. The dialectics and complications of developing bonds within the therapeutic relationship brought clearly into focus the conflicts associated with deepening attachment (Migdow, 2011). For many individuals who have experienced complex childhood trauma, the therapeutic relationship may be the first context in which secure attachment is experienced, leading to plausible feelings of fear, ambivalence, and uncertainty. Such tensions were reflected in clients' heightened sensitivity to deepening bonds and the simultaneous longing for and fear of closeness (Liotti, 2004).

Clients' experiences of recognising, sitting with, and moving through fear, in the presence of a healthy attachment figure within the therapeutic relationship, indicate the

fundamental importance of the therapist as a 'good enough parent' (Winnicot, 1953). Through remaining attuned to the client's emotional state and responding sensitively to their needs, opportunities are also created for shared regulation within the therapeutic relationship (Andriopoulou, 2021), supporting therapeutic breakthroughs as clients face their fears, leading to safety within therapy processes. The findings also suggest that experiencing healthier attachment relationships provided clients with a relational blueprint that extended beyond therapy itself, as seen in Hirakata's (2009) participants. This aligns with Herman's (1992) stage-based model of recovery, where establishing safe and trustworthy relationships forms the foundation for subsequent healing. Ultimately, the therapeutic relationship moves beyond technique to become an active, relational intervention, offering a reparative experience that challenges insecure attachment patterns and supports the possibility of developing increasingly healthy and secure connections in clients' lives (Pearlman & Courtois, 2005).

The threads of attachment characterise many of the themes that were developed in the analysis. For example, the core conditions of therapy relating to attunement and empathy, supporting clients to rebuild trust and safety, likely enhanced the attachment relationship between clients and therapists (Pearlman & Courtois, 2005). In the theme *therapists with courage*, therapists moving beyond the usual limits of therapy may have yielded positive experiences in therapeutic relationships due to the development of attachment security (Gelso, 2019). Interestingly, the development of a new attachment relationship in therapy reflects the courage required by clients to begin trusting therapists, emphasising that both parties are taking risks in the shared venture of the therapeutic relationship, deepening security and safety (Pearlman & Courtois, 2005).

Strengths and limitations

This is the first review to focus exclusively on the therapeutic relationship in the context of therapy experiences with clients with complex childhood trauma difficulties. A similar review was carried out that investigated the ways that people with histories of sexual abuse experienced talking therapies for sexual trauma (Dawood et al., 2023). However, this review analysed sexual abuse across the lifespan, did not incorporate therapist perspectives, and was specific to sexual abuse rather than multiple forms of abuse and childhood maltreatment/trauma. A strength of this review was the synthesis of perspectives between clients and therapists, where both parties play a significant role within the therapeutic dyad, offering a wider breadth of insight and experience. Another strength of the review was its inclusion of studies guided by the experiences of research participants, rather than psychiatric diagnoses. Selecting studies by diagnostic frameworks may have limited insights into the pervasive impact of traumas as described in the literature.

Limitations related to several studies recruiting participants who had experienced a wide range of interpersonal traumas, such as rape and sexual assault, in addition to complex trauma. Additionally, many therapists worked with a broader range of populations. This may have implications for the findings, as their perspectives/experiences might not be solely related to complex childhood trauma. However, the nature of complex trauma is rooted in interpersonal relationships (Herman, 1992), and frequently those experiencing interpersonal trauma over the course of their lives recall traumatic events starting in childhood. Therefore, these views were not fully discounted, and efforts were made to ensure that most participants in studies had experienced/worked with complex childhood trauma as the main presenting difficulties. There are limitations related to age-related, cohort, and generational differences that were not fully captured within this systematic review. The included studies drew on samples that varied widely in age, meaning that older and younger participants may have differed substantially in their experiences and perspectives of therapeutic relationships due to

cultural norms, developmental stage, impact of the duration of trauma difficulties, and potential differences in emotional expression. These influences were not examined in depth within the review and may therefore have shaped both the findings of the individual studies and the overall conclusions drawn.

There are limitations imposed by the varying methodologies across the included studies. For example, in relation to recruitment, some clients referred to current therapies, and others discussed previous therapies. This may introduce recall bias and differences in emotional immediacy, which may have influenced how experiences were reported. Therapists drew upon experiences across clients, and in other studies, there was more specificity within clinical pairs. This could affect the depth and specificity of the data, potentially diluting nuanced relational dynamics. The recruitment strategies varied, which may lead to selection bias. For example, clients who volunteered to discuss past therapy may differ systematically from those currently in therapy. Additionally, those recruited by their therapists may have felt more inclined to speak about the therapeutic relationship in a positive way, introducing bias into the findings. These methodological differences create challenges in synthesising themes across studies, as the context of therapeutic relationships and recruitment strategies differed.

Therapeutic models varied across studies, and in some of the articles, these were not reported. This may have implications for therapists and client perceptions and experiences within therapeutic relationships. For example, higher rates of anger relating to interpretations may have occurred because of psychodynamic inferences (Dalenberg, 2004). Another limitation relates to the ambiguity of the term complex trauma. This study attempted to introduce specificity into the concept through outlining trauma related to childhood abuse and mistreatment, rather than complex trauma difficulties experienced as a result of war, being a refugee, or because of domestic/community violence. This may have led to a lack of cultural

diversity in the final papers used in the review. However, it was necessary to introduce boundaries around the concept to maximise the potential for the findings being applicable to a particular group and to promote homogeneity across the sample.

Clinical Implications

The findings of this review highlight that the therapeutic relationship is itself a core intervention in work with individuals who have experienced complex childhood trauma. Clinical implications emphasise that therapists should prioritise safety and trust within the therapeutic relationship in response to heightened relational sensitivity that arises from early experiences of abuse and/or mistreatment. Clinicians are encouraged to normalise trauma responses as adaptive survival strategies, to reduce shame and develop trust. Therapist qualities such as genuineness, empathy, courage, and measured self-disclosure can humanise the therapeutic process, while attention to equity and power assists in reducing the risk of replicating past abusive dynamics. Clearly negotiating boundaries and flexibility in therapeutic processes supports establishing containment and safety. Systemically, the review highlights the importance of longer-term, trauma-informed care models, as short-term interventions may be insufficient for building the relational security and depth required for recovery in this population.

Conclusion

This systematic review narratively synthesised 12 qualitative studies on therapeutic relationships in the context of complex childhood trauma and identified six core themes: ‘The core foundations are fundamental’, ‘From chaos to coherence’, ‘Therapists with courage’, ‘We are in this together’, ‘Boundaries’, and ‘A new attachment relationship’. The review concludes that the therapeutic relationship functions as a reparative experience, offering clients opportunities to rebuild trust, reframe their difficulties, and develop healthier

relational frameworks. While further research is needed to refine practices such as therapist self-disclosure, the evidence supports the centrality of safety, trust, relational depth, and attachment as the foundations of therapeutic change for individuals who have experienced complex childhood trauma.

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Chapter 3: Bridging Chapter

Chapter 3: Bridging Chapter

The systematic review documented in Chapter 2 explored the qualities of the therapeutic relationship from the perspectives of clients receiving (or those who had received) therapy and therapists. In both populations, there were discussions of particular therapeutic encounters and generic experiences. Throughout the studies, key issues regarding the qualities of the therapeutic relationship were reported. In particular, the significance of the core interpersonal and relational foundations of the relationship, working collaboratively, and maintaining appropriate boundaries was emphasised. Perhaps most fundamentally, the systematic review highlighted that the attachment between client and therapist was essential within the therapeutic relationship, in developing trust and safety, and leading to significant shifts in therapeutic progress. This finding highlighted the importance of the relationship itself being the 'work' in therapy for people with complex childhood trauma difficulties.

The systematic review found that early attachment disruptions experienced in complex childhood trauma influenced therapeutic relationships in a multitude of ways, as demonstrated by the themes that were developed. Therapeutic relationships were seeking to heal interpersonal challenges and trauma-related sequelae as a core function within the dyads through the development of a new reparative attachment relationship. The findings demonstrated the ways that experiences of childhood complex trauma create challenges within therapeutic relationships. This opens the door to further questions regarding individuals' experiences within other relationships in their lives. As the difficulties associated with complex trauma reside so heavily within the interpersonal sphere, further exploration of individuals' experiences of their personal relationships adds further insights into the nature of their experiences, building upon the findings from the systematic review.

In Chapter 4, the empirical paper seeks to understand the views and experiences of people with complex trauma difficulties regarding the impact of their trauma-related challenges on their personal relationships. This part of the research was conducted via a qualitative method to gain a rich and in-depth understanding of participants' meanings and experiences and provide a voice to this population. The purpose of the empirical study also supports the development of understanding a phenomenon that has minimal existing qualitative research. The identified themes will be presented in the following chapter, with additional methodology considerations reported in Chapter 5.

Chapter 4: Empirical Paper

Chapter 4

Exploring the impact of complex trauma on personal relationships: An Interpretive Phenomenological Analysis

Caroline Mangham, Lawrence Howells & Paul Fisher

Norwich Medical School, University of East Anglia, Norwich, NR4 7TJ, UK

Cambridgeshire and Peterborough NHS Foundation Trust

Norfolk and Suffolk NHS Foundation Trust

Corresponding author: Caroline Mangham (email: c.mangham@uea.ac.uk)

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Author guidelines are outlined in Appendix A.

Manuscript limit: 35 pages. Font: Times New Roman, Size 10

Word Count: 8000 (excluding Abstract, Table and References)

Abstract

Complex trauma encompasses prolonged and repeated exposure to traumatic experiences, typically occurring within caregiving or interpersonal relationships, and is often associated with early developmental adversity. Despite growing recognition of the relational impacts of complex trauma, there remains a scarcity of empirical research qualitatively exploring how trauma shapes individuals' experiences within personal relationships. This study aimed to address this gap by investigating the impact of complex trauma on personal relationships. A qualitative methodological design was employed, using Interpretive Phenomenological Analysis (IPA; Smith et al., 2021). Ten participants were recruited via two NHS Trusts in East Anglia, UK. Ethical approval was obtained from the NHS Research Ethics Committee. Participants engaged in semi-structured interviews, which were transcribed and analysed following IPA principles. Four group experiential themes and related subthemes were developed: (1) *The void of attachment needs*; (2) *Inner narratives that shape our relationships*; (3) *Challenges in relating with others*, encompassing '*dynamics in relationships*,' '*self-preservation and protection*,' '*struggles in communication*,' and '*triggers in relationships'*; (4) *Change and growth*, including '*small circles where we feel secure*' and '*learning and growing through relationships*.' Findings indicated that attachment difficulties continued to manifest in personal relationships, often leading to dependence or withdrawal. Core beliefs of worthlessness and mistrust affected communication and boundary-setting, while intense trauma-related emotional reactions created conflict and, at times, fear in others. Communication challenges were emphasised. Participants reported feeling safer in smaller or more intimate relational contexts and experienced meaningful personal and relational growth through personal relationships.

Keywords: Complex trauma, CPTSD, childhood trauma, interpersonal trauma, personal relationships

Background

Complex trauma, often rooted in early and prolonged exposure to interpersonal harm, has profound implications for psychological development and relational functioning (Maercker et al., 2022). Complex trauma has been described as encompassing chronic and severe traumatic events, usually occurring in childhood (Nieuwenhove & Meganck, 2019). Events are reported as repetitive and occurring over extended periods, within the context of caregiving/interpersonal relationships, and encountered at sensitive stages of brain development (Ford & Courtois, 2009; Kliethermes et al, 2014). The term complex trauma is also used to describe the psychological and emotional sequelae that impact a person's personality and psychological development and fundamental trust in relationships, which occur because of traumatic experiences (Kliethermes et al., 2014; Nieuwenhove & Meganck, 2019). Therefore, complex trauma is used as a term to describe the original traumatising experiences and resulting difficulties (Kliethermes at al., 2014). People with complex trauma experience psychological difficulties associated with single-incident trauma, including reexperiencing, avoidance, emotional numbing, and hyperarousal. Their psychological experience is complicated through struggles with emotional dysregulation, negative self-beliefs, and problems in relationships (Melton et al., 2020; Nieuwenhove & Meganck, 2019), resulting in a more pervasive pattern of difficulties that impact personal and interpersonal functioning over the life course when compared with single-incident trauma (Ehring & Quack, 2010; Nieuwenhove & Meganck, 2019).

To date, the definition of complex trauma remains ambiguous within the clinical and research spheres, although consensus exists regarding increased exposure to harmful or dangerous events in interpersonal relationships (Cloitre et al., 2011; Herman, 1992; van der Kolk et al., 1996). Conditions such as Complex Posttraumatic Stress Disorder (CPTSD; Cloitre et al., 2013; Herman, 1992), Disorders of Extreme Stress Not Otherwise Specified

(DESNOS; Ford et al., 2006; Pelcovitz et al., 1997), and Developmental Trauma Disorder (van der Kolk, 2005) were proposed to capture the complex psychological effects of prolonged or repeated interpersonal trauma. Finkelhor et al. (2007) found that poly-victimisation in childhood was highly predictive of trauma symptoms, and trauma outcomes may be increasingly chronic and severe with an earlier age onset, due to the development of the human brain and attachment needs of the child (Cook et al., 2003; De Bellis et al., 1999; Ogle et al., 2013). Becker-Weidman (2009) proposed that complex trauma is usually associated with a disrupted attachment relationship between parent and child. Such findings may overlook the impact of complex trauma events that occur throughout life, not always rooted in early childhood, where Roth et al. (1997) found that age of onset was not associated with a more pervasive pattern of difficulties. It is documented that complex trauma outcomes worsen with longer durations of trauma exposure (Cohen et al., 2002), experiencing multiple types of trauma (Finkelhor et al., 2007; Teicher et al., 2006), and traumatic experiences being rooted in interpersonal relationships (Ehring & Quack, 2010).

The interpersonal dimension of complex trauma is associated with other forms of interpersonal trauma, including domestic abuse, being a civilian or refugee war victim, genocide, and other forms of organised violence (Herman, 1992; Newman et al., 1997). These findings highlight the importance of broadening the range of victimisation when assessing and researching complex trauma, where the psychological and interpersonal consequences across multiple types of victimisation closely relate (Nieuwenhove & Meganck, 2019).

Complex trauma and relational disruption

The internal working model of relationships is proposed to form the foundation for patterns of relating to others throughout life (Zilberstein & Messer, 2010). However, the

experience of complex trauma disrupts this blueprint by impacting an individual's core beliefs, attachment systems, and connections with communities (Briere & Jordan, 2009; Ford & Courtois, 2021; van der Kolk et al., 1996). This often leads to difficulties in interpersonal functioning, including struggles with trust, higher rates of revictimisation, fears of being abandoned or unloved, challenges in managing emotions, and exhibiting survival behaviours based on personal beliefs and schemata (Bowlby, 1969; Beck et al., 2009; Fonagy & Bateman, 2008; Mikulincer & Shaver, 2003; Nieuwenhove & Meganck, 2019; Pearlman & Courtois, 2005). Furthermore, people with complex trauma may struggle with increased withdrawal and avoidance, where interactions with others trigger trauma-related responses (Statdmann et al., 2018; Nestgaard Rod & Schmidt, 2021). People with complex trauma are likely to endure traumatic relational experiences throughout life and often encounter interpersonal difficulties in personal relationships and with those in positions of care, potentially resulting from activated belief systems from past traumas (Duckworth & Follette, 2011; Tummula-Narra et al., 2011).

There is a scarcity of qualitative research that gives a voice to the dilemmas of negotiating personal relationships for people with complex trauma (Spinazzola et al., 2018; Tummula-Narra et al., 2011). Tummula-Narra et al. (2011) identified themes of safety, new ways of relating, and a changing sense of self in relational development for trauma survivors in therapy. This qualitative study developed an understanding of healing through connection, rather than immersing solely in the experience of personal relationships as impacted by complex trauma. Melton et al.'s (2020) large-scale systematic review on interventions for adults with complex trauma highlighted a lack of knowledge on first-hand narratives, recommending further research to explore lived experience of complex trauma difficulties.

Historically, there has been poor recognition of traumatic histories in people with complex trauma difficulties (Herman, 1992), and their relational experiences are not well

understood (Mauritz et al., 2013; Melton et al., 2020). Despite growing awareness and theoretical knowledge of the psychological and relational effects, less is known about the direct experiences of complex trauma shaping adult relationships. Qualitative approaches help to establish comprehensive insights into the impact of complex trauma on personal relationships through the exploration of depth of experience and meaning. Such aspects may be overlooked in quantitative research. By exploring personal narratives, clinicians may become more adept at adapting therapeutic approaches to meet service users' needs, emphasising trauma-informed and culturally sensitive practices. Findings may support the development of attachment theories of trauma through grounding them in real-life experience, leading to improved care within services, where effective treatment for complex trauma often involves addressing attachment-related issues within therapeutic relationships (Pearlman & Courtois, 2005). This study aimed to gain an understanding of the ways that complex trauma impacts individuals' experiences of their personal relationships.

Research Question

How do people experience the impact of complex trauma on personal relationships in their day-to-day lives?

Methods

Design

The research utilised a qualitative methodological design, using Interpretive Phenomenological Analysis (IPA), to explore participants' experiences of the impact of complex trauma on their personal relationships. The approach uses exploration, description, interpretation, and situating to understand how people make sense of their experiences (Smith et al., 2009; 2021). IPA was chosen as it provided idiographic depth to capture the complexity and nuance of the impact of complex trauma on personal relationships and

associated meanings. This approach was considered advantageous beyond other methods such as Thematic Analysis (Braun & Clarke, 2006) due to its suitability for understanding the complex personal lived experiences of participants.

Philosophical underpinnings of the research

This study is informed by a critical realist ontology (Fletcher, 2016), which assumes that while an underlying reality exists, including traumatic events and experiences, our understanding of reality is influenced by subjective experience and social context. The research adopts an interpretivist epistemology, emphasising the co-construction of meaning between researcher and participants (Crotty, 1998; Denzin & Lincoln, 2011). This stance supports Interpretative Phenomenological Analysis (IPA), which explores how individuals make sense of lived experiences of trauma and relationships, while recognising that these interpretations are shaped by personal, social, and cultural frameworks (Smith et al., 2021).

Participants

A purposive sample was used to recruit participants from NHS secondary care mental health services. Participants were adults, over the age of 18, receiving services from NHS Community Mental Health Teams (CMHTs) across two Mental Health Trusts in East Anglia.

Participants had a history of chronic and severe trauma events and identified as experiencing a range of complex trauma difficulties, including emotional dysregulation, negative self-beliefs, difficulties in relationships, avoidance/emotional numbing, hyperarousal, and reexperiencing of traumatic events. There was no requirement for participants to have a psychiatric diagnosis to take part to promote inclusivity in recruitment processes. Participants were deemed by service professionals, the primary author, and themselves as able to provide full informed consent to take part in the study. Participants

were not detained in an inpatient service or experiencing a mental health crisis or elevated levels of risk at the time of recruitment or interview.

Ten participants were included in the study. Participants met the inclusion criteria, which outlined their experience of complex trauma events and difficulties, at the time of recruitment and interview (Appendix D). Participant characteristics, including gender, age range, ethnicity, sexual orientation, and relationship status, are shown in Table 1.

Table 1.

Participant Demographics

Participant Pseudonym	Gender	Age range	Ethnicity	Sexual Orientation	Relationship Status
Dawn	Female	55-64	White British	Heterosexual	Divorced
Wray	Male	45-54	White British	Heterosexual	Separated
James	Not disclosed	25-34	White British	Not disclosed	Married
Green	Female / Non binary	25-34	White British	Gay / Lesbian	Cohabiting
Sara	Female	35-44	White British	Bisexual	Single
Jessie	Female	45-54	White Scottish / British	Pansexual	Divorced
Elizabeth	Female / mixed identify gender	25-34	White European	Bisexual	Single
Mary	Female	45-54	White British	Heterosexual	Divorced
Janet	Female	45-54	White British	Heterosexual	Married
Emma	Female	45-54	White British	Heterosexual	Married

Note: Elizabeth's gender identity was handwritten into the demographics form.

Procedure

Ethics

Ethical approval was obtained from the NHS Research Ethics Committee (REC:24/NI/0040) and the relevant NHS Trusts' Research and Development departments (HRA approval letter, Appendix B; REC approval letter, Appendix C). Letters of access were obtained to enable recruitment for the study.

Recruitment

The researcher attended locality CMHT meetings to discuss the study. The research poster was shared (Appendix D). In CMHT MDT and Psychology meetings, service professionals and gatekeepers used the exclusion and inclusion criteria (Appendix D) and their clinical knowledge of service users to identify potential participants. These meetings did not include the primary author and may have imposed a degree of subjectivity within recruitment processes. Upon identification of potential participants, service professionals contacted them over the telephone or during routine appointments to discuss the study. If interest was expressed about participation**,** service professionals provided potential participants with the participant information sheet (Appendix E) and consent to contact form (Appendix F). Potential participants expressed their interest in taking part, based on this information, and consented to be contacted by the primary author or contacted the primary author directly via email. The primary author telephoned potential participants to discuss the research. Participation in interviews was voluntary, and participants were assured that their mental health treatment would not be affected by nonparticipation. The informed consent form was signed immediately before the interviews commenced (Appendix G).

Interviews

The primary author developed a topic guide, in partnership with a PPI group of individuals who experienced complex trauma difficulties, to guide the interviews. The topic guide consisted of two main open-ended questions and four further open-ended questions detailing areas for exploration (Appendix H). Prompts were used to explore responses. Before interviews commenced, participants were encouraged to ask further questions. They were informed of their ability to withdraw from the study from that date, up to two weeks

after the interview. Interviews were conducted between July 2024 and November 2024, with each participant taking part in one semi-structured interview.

Participants were interviewed at their home, a local NHS clinical site, or virtually via MS Teams, according to participant preference. The primary author noted reflections during and after interviews to develop awareness of their own beliefs and experiences. Interviews lasted between 60 and 105 minutes and were audio recorded. Participants were debriefed following the interview and they provided a pseudonym to be used in the analysis and write-up. A debrief form was provided (Appendix I). At the end of each interview, participants received a £20 Love2Shop voucher as a thank-you gesture for taking part.

Analysis

To ensure deep engagement with the data, the primary author transcribed the interviews verbatim. Participants' personal information was anonymised. Transcripts were analysed by the primary author following the IPA guidelines outlined by Smith et al. (2021) using NVivo14 (Jackson & Bazeley, 2019). Each transcript was read multiple times to enhance familiarity with the text. When reading the first transcript, detailed annotations were made, including descriptive, linguistic, and conceptual observations. From these notes, Personal Experiential Statements (PESs) were developed. PESs were either directly drawn from the data, developed through conceptual interpretation, or described based on observed patterns (Fade, 2004). After coding the entire transcript, Personal Experiential Themes (PETs) were developed and organised, and connections between them were explored, leading to the development of a final group of refined PETs. This process was repeated for each subsequent interview, with themes from the first transcript bracketed off to allow for fresh analysis (Smith et al., 2021; Smith & Nizza., 2022).

After all transcripts were analysed, the primary author examined the data for patterns, identifying commonalities and divergences in participants' experiences to highlight areas of similarity and contradiction (Smith & Shinebourne, 2012). Recurrent themes were cross-checked against the original data, with supporting quotes documented for each theme. As the analysis evolved, some themes were excluded due to a lack of sufficient evidence. The process remained iterative, involving continuous movement between stages of analysis to ensure that the themes accurately represented participants' responses. Finally, a structured list of Group Experiential Themes (GETs) and subthemes, along with illustrative examples, was compiled to convey the study's findings.

Researcher Reflexivity and Interpretive Lens

The primary author's professional experience working with complex trauma populations and commitment to social justice informed engagement with the data, shaping the interpretive lens throughout the analysis. This lens heightened sensitivity to issues of power, oppression, and relational dynamics, which supported a deeper understanding of the ways participants described their interpersonal and emotional experiences. The primary author's social justice values guided a strong emphasis on centring participants' voices from a non-pathologising stance, to ensure that relational and emotional challenges were understood as meaningful responses rather than individual deficits. By acknowledging these influences, the primary author aimed to ensure transparency in the construction of the analysis and the interpretative position underpinning the study.

Quality Assurance

A reflective diary was used throughout the study, contributing to quality, validity, and reflexivity within the IPA process (Smith et al., 2021). Journaling through memos within NVivo14 aligned with the double hermeneutic central to IPA, where reflections on the

analytic process were also recorded (Vicary et al., 2017). Ongoing reflective discussions were held with the research team at each stage. To enhance the credibility of the analysis, PESs, PETs, and GETs were developed and shared with the research team, ensuring that emerging interpretations were grounded in the data. The research team collaboratively discussed the findings to support the validity and trustworthiness of the interpretations.

Results

Four Group Experiential Themes (GETs) and related subthemes were developed in the analytic process: (1) The void of attachment needs; (2) Inner narratives that shape our relationships; (3) Challenges in relating with others, encompassing: '*dynamics in relationships*,' '*self-preservation and protection*,' '*struggles in communication*,' and '*triggers in relationships'*; (4) Change and growth, including '*small circles where we feel secure*' and '*learning and growing through relationships*.'. GETs and supporting subthemes are discussed.

The void of attachment needs

This theme captures the ways that participants experienced the impact of traumatic early relationships within their personal relationships. There was a sense of relationships being influenced by early attachment experiences. Wray articulated an awareness of how attachment needs played out in his intimate relationships, describing an innate drive to seek a mother figure: *'I was weak in myself that I'd resorted to just living.. a lie… which made me latch onto something, and basically what I was looking for was a substitute mother.'.*

Dawn described a strong sense of yearning for care and love from others to ameliorate emotional and relational difficulties experienced in everyday life in the context of experiencing rejection with her mother as a child: *'it would be everything, just to be wanted and loved and cared for and cared about…. I want to feel safe, feel cared about, feel loved,*

feel wanted..'. Dawn's sense of unfulfilled yearning seemed to create dependence on family members, leading to suffering when her needs weren't met. Similarly, Mary expressed how unfulfilled needs for love led her into abusive relationships as a younger woman: *'...when you've come from all that past. I saw that as, Oh my God, someone finally wants to look after me and take care of me. So I went ahead and got married.. He turned out to be violent'.* James expressed a need for love and closeness from others because it was something they felt they did not experience within family relationships: *'I think it's kind of like rejection. I just wanted someone to love me, to treat me with respect, like I've never really had that even with my family that I've never had that..'*. This seemed to create a sense of 'life or death' dependency within their intimate relationship: *'I was literally on the verge of killing myself. And then she walked into my life.. if we divorced I wouldn't have lasted 5 minutes.. cause I can't see my life without her now'.* (James).

Sara made sense of attachment difficulties resulting from experiences of moving between different care settings as a child, leading to a constant sense of impermanence and dehumanising of people: *'it's occurred to me that people to me in personal relationships feel like voids because they're not really real and everyone's temporary in my life.'*. The void did not lead to a deep sense of longing or yearning about relationships in the manner that other participants experienced: *'But people don't register in the same way with me… Seems like a funny thing to say.. they're just things, and they're not, they're people. They're human beings, but that I have to deal with'.* (Sara). Her experience led to challenges in interpersonal relationships, where managing closeness was characterised by a profound sense of complexity.

Inner narratives that shape our relationships

This theme represents participants' expressions of deeply entrenched belief patterns, which they sensed developed because of traumatic experiences within attachment relationships, impacting their personal relationships. Dawn expressed a deep wound relating to self-beliefs, emerging from narratives bestowed upon her as a child, leading to acceptance of abuse in intimate relationships*: 'I've had a broken nose, broken jaw, broken eye socket… I thought I deserved it and carried on as normal… It goes back with 'I'm evil and wicked so therefore I deserve punishment''*. Dawn's beliefs seemed to perpetuate a cycle of feeling undeserving and bad, providing a rationale for negative experiences in relationships.

Other participants expressed how trauma-related self-beliefs complicated the development of personal relationships. Emma described deeply rooted negative self-beliefs that held her back from developing relationships as a younger woman: *'I saw myself as the devil incarnate… like evil personified. So the idea that I should inflict myself on anybody was, you know'*. She described thought patterns causing difficulties in resolving everyday stressors with her husband:

> *...he knows I'm going around that cycle of, "I'm the bad one, that must mean I'm a bad person"… So he'll be like, "I don't think you're a bad person"…. And I'm like, "well, I wasn't thinking I was a bad person. But now, are you actually thinking I'm a bad person?"*. (Emma).

Green described beliefs that were formed growing up in an abusive family and religious community, regarding not being good enough, emphasising the impact on their current relationship:

> *I often struggle with feeling like I'm just not a good enough daughter. Like maybe if I was a better daughter they would have loved me more… and that does leak into other*

stuff… Like I often have bickers with my fiancé because I say things like 'I know I'm not a good wife, but I'm trying to be.

The depth of Green's paranoia and thought cycles also impacted relationships with their friends' children: *'maybe I'm too mean? Or maybe I'm too nice?... but I also then have that other level of what if one day I just wake up and then I'm a paedophile'?.* (Green). These repetitive and unrelenting cycles led to difficulties resolving relational issues and feeling secure within relationships. Elizabeth described a repetitive cycle of relational trauma impacting self-beliefs, leading to further traumatic experiences in relationships:

I think the damage that is done to my internal beliefs and my self-image and everything.. it's done a nice wopper on that one… it left me to be very vulnerable to other people's crap because you're an easy target because you don't have any self-value or worth.

She had pulled back from interpersonal relating because of her realisation of these difficulties.

Challenges of relating with others

This theme captures the intricacies of participants' experiences of challenges relating to others through interpersonal dynamics, patterns of avoidance and mistrust, difficulties in communication, and triggers. Four subthemes were developed to represent these experiences:

Dynamics in relationships

Participants described patterns in relationships that served in navigating the complexities and dangers of interpersonal relating, often at the expense of their own needs. Jessie strongly resonated with a sense of adapting herself in her personal relationships, describing an experience where she felt told off by her ex-partner for swearing: *'I felt*

ashamed… It triggers me to start fawning and people pleasing… my dynamic with my mum, it's fawn. I call it "are you OK, are you OK, are you OK". Because if you're OK, then I'm OK'. Similarly, Mary described familiar patterns of adapting behaviours in personal relationships linked with traumatic earlier life experiences:

> *I take care of everybody else. That's my job. I'm the matriarch. Because of what I went through.. I take care of all my friends. But the one person I don't take care of… me…And I still do it now. People pleasing people pleasing*.

Emma explored how patterns with family served a protective function through maintaining the emotions of others, masking her discomfort and mental health difficulties, therefore reducing the risk of further invalidation and ongoing harm: *'I'm known as the family diplomat. That's my role. I don't cause any upset… I'm the one who listens to everybody and appeases everybody. So that's my role, "Emma doesn't ever cause a fuss"'*.

Sara spoke about subconscious patterns that characterised intimate relationships and friendships and a lack of balance within these: '*I would always end up in the role of being the weaker one in the relationship, being less than... and somehow accidentally without meaning to, encourage that mindset from my partner..'.* There were devastating consequences relating to these patterns, leading her into dangerous friendships:

> *I would instinctively put myself in the victim role around him and I had to stand up and refuse to allow him to contact me directly.. because he told me to kill myself, and I actually considered doing it because I was programmed to do what that person wanted me to do.* (Sara).

Self-preservation and protection

Many participants described patterns of avoidance or difficulties trusting others, distancing themselves mentally or physically from others. Janet expressed a high sense of

mistrust in other people, aside from her husband, which caused difficulties in friendships: *'I think it's made it difficult to either make or keep friends….Its trust, I don't I don't trust anybody. That's what it is. I don't trust no one'*. Similarly, Emma described having no framework for establishing a sense of trust in people, besides her husband, leading to distance and avoidance in friendships*: 'Letting someone in… It feels really untrustworthy. The idea that I would trust somebody with anything about me or my feelings..'*.

Other participants described problems with trust, creating challenges within their existing intimate relationships and friendships. Green talked about interpreting a loving gesture in the context of previous abusive experiences with family:*'..the first time that Jess bought me a present just out of nowhere, I was like, "what have you done"? "What's going on"? "What do you need to tell me"?... I couldn't trust that that was the truth...*

Conversely, Mary described the hypervigilance and fear she experienced with others almost like a superpower, which helped her to make safe relational choices: *'the chap that told me he was separated and wasn't… I said "it's my cptsd that keeps me safe from wankers like you"'*. She expressed a sense of boldness in her relationships, offering trust in the face of uncertainty:

> *I'm not totally sure about the people I let into my life, but when you've gone through life with trust issues, it gets to a point where you just think to yourself, you've got to trust them because you're never going to talk to anybody ever again. If you don't start.* (Mary).

Janet described avoiding family and friends when she was experiencing complex grief. Rather than seeking connection and closeness, she sought to blame others: *'I didn't speak to them for eight months. It was all their fault. Blamed them and pushed everybody*

away….I just didn't want to talk to nobody. It's avoidance. You know, I just… Hid away, in my bedroom. Kept out the way'.

Struggles in communication

Many participants described challenges in communicating effectively, leading to relational difficulties. Dawn expressed a sense of unintentionally offending people, perpetuating conflict or distance in relationships: *'Sometimes I'm in a muddle and I might say the wrong thing… I might say something that can be taken the wrong way and as it goes back through my head I say 'Oh did I actually say that'*. She also described being distracted by her internal thoughts, leading to obstacles in communicating with others: *'Yeah because also going through my head is all the shit all the time as well. So I'm occupied by what I'm saying, what I'm saying in the future.. what I can and can't say'.* (Dawn).

Sara spoke about withholding information within a previous intimate relationship: *'I was very selective about what I did and didn't tell him.. because I didn't feel like I should have to or want to. And I think it was a barrier'*. She explored how these difficulties influenced the ways others perceived her in relationships:

> *And it was never sustainable because they would see me as weak and fragile. I'd hit my limit and bring the thunder… stand up for my own rights. And they wouldn't like it. It would challenge their preconceived ideas of me of being fragile and weak.* (Sara).

Wray described challenges communicating with previous partners, which fed into relational patterns of avoidance and attack: *'I'd be less responsive. I'd shut down. I wouldn't speak… I would create an argument for the purpose of escalating that argument to the point where I would leave'*. He hid his trauma, which led to a lack of openness and understanding within relationships: *'I didn't wanna share it because I just felt that they would make them*

judge me differently'. (Wray). Green identified that communication with their partner was impacted by challenges understanding emotions, being linked to earlier relational trauma within the family and religious community:

> *'It definitely affects my communication.. I don't always know how to communicate my emotions because I never really did. Until I left the group and met Jess..It's a lot of work for me to say. "Hey, you really upset me with what you said today"..'.*

Triggers in relationships

Participants described experiences of feeling easily triggered within personal relationships, attributing this to the emotional aftermath of complex trauma, causing challenges in relationships. Green talked about the ways that day-to-day conflicts with their partner triggered fears of abandonment and an immediate need to flee:

> *She said, "you just never pick up off yourself".. And I got really triggered, really quickly. I remember saying to her that I didn't want to be around her anymore. And literally in my pyjamas with no shoes on, my feet, running and getting in my car and Jess coming out… and being like, "stop, breathe, What the hell"? Because I was just determined I was gonna leave.. That was it. "You don't want me"? "I won't be here". (Green).*

Janet spoke retrospectively about the impact of trauma on her ability to manage her emotions, leading to extreme conflicts with her husband in the earlier stages of their marriage: *'I just flipped.. because he dropped the shopping on the floor. So I punched him in the face… and we were physically fighting… it was just something simple like that. Just dropping the shopping down'.*

Elizabeth reflected on rage reactions causing fear in others, which led to her not feeling wholly accepted as a person:

When I have the BPD rage, I've not met a person that does not react to it. That does not have that instinctive fear… I'm not in control but I still see what happens… I'm grateful that my family do kind of accept that it's part of me, but they're instinctively afraid of it… if someone is afraid of it, there is an element of lack of acceptance, no matter if they do actually accept it.

Wray described feeling triggered during moments of close personal contact because of the abuse he experienced, leading to difficulties in intimacy with his partner, during moments when she was trying to be supportive:

All I wanted to do when I was in that corner was get away from her, but I let her hug me and I said, "look can you let go? Can we stop? Can I go away now? Because I'm feeling a bit and it's not because of what you're doing, it's because of what I'm feeling".

Change and growth

This theme captures participants' experiences of growth and healing on a personal and relational level, with an interplay between the two, and emphasises the function of safety in personal relationships. Two subthemes were developed to represent these experiences:

Small circles where we feel secure

Participants described seeking community, safety, and understanding with smaller circles, with a conscious decision to pull back from relationships or associations that may be harmful. Mary described authentic bonds, characterised by acceptance and mutual understanding*:*

I've got maybe three-four real true friends. I know loads of people, but they're not friends. Friends are people that know me and accept me for who I am. We've all got

issues. We all take care of each other… even now because of things like cptsd, we're still making mistakes with men and with drugs, but we don't judge each other over it, we embrace each other.

Similarly, Green had found community within a smaller group of friends, bonded by their shared difficulties: *'So I don't have… Very many close friendships and there's four of us that are all best mates, and that's because we all have mental health and we're all neurodivergent and we're all a bit of a mess'*. These relationships countered some of the losses that Green experienced when they left the religious community and family, helping to heal traumatic loss.

James passionately spoke about the creation of a new family, healing the grief associated with severed relationships with their birth family: *'Honestly, it feels like I've got a dad. David is just the loveliest man ever… I call him Daddy David and mummy Claire, because they just mean so much to us…'.* James also reflected that comfort within this system held them back from seeking friendships: *'So it's a difficult one because I do need to make them because at the moment it's just me and Nadia, Claire and David and her foster children. so I kinda need to but I don't'.*

Janet described not having many friendships, although she expressed being bonded to others through shared experiences of complex grief relating to the traumatic death of her son:

I haven't got a lot of friends. me and Tristan go to a bereavement group for parents that have lost children and there's a girl there… She lost her son… and we're quite good friends now… I can talk to her about Shaun.. you see, people don't like me talking about Shaun.

Emma maintained a close and trusting connection with her husband, where there was no framework, or expressed need for external relationships: *'The idea of having that kind of a*

close relationship with anybody is lost on me. I suppose except my husband…But outside of him. Not got anybody that I can particularly say that I have any real closeness to'.

Learning and growing through relationships

Most participants described a journey of personal and relational growth. Some of these developments were well-formed and deeply reflective. Jessie articulated that avoiding relationships was contrary to healing. She conveyed a sense of courage and optimism within personal relationships despite the ongoing challenges they presented: *'your patterns repeat in relationships. They present opportunities to recognise and work on those patterns and heal them. And if you don't have relationships, you might not have those opportunities'.* (Jessie).

Wray's narrative was one of profound change through his experience of relationships aided by therapy. His partner was significant in his growth: *'She empowers me. She tells me when it's my ego messing with her with things. She tells me that basically don't project when I do and I do project'*. He described how this 'mirror' led to a profound change within himself and a loss of control from previous relational patterns: *'But the control now, is control of myself, And the weirdest thing is I'm now at the stage where I absolutely love Amelia, but I'm equally happy knowing I'm good on my own'.* (Wray).

Emma described being deeply moved by her relationship with her husband and authentic connections made at work. There was a sense of safety in human relating, without the potential danger associated with friendships, which helped her to feel valid as a person, in the context of previous invalidation from family: *'That gets me… somebody to not just to be paid lip service, to actually know that somebody thinks you are valid and what you bring to any situation is valid. That's huge…That can knock me off my feet..'*. Sara also spoke about the value of working relationships reflecting her validity as a person: *'I feel like I'm starting to have professional relationships with peers, people that can see me as strong and fragile*

equally and valuable for both'. Sara expressed wanting to forge a stronger sense of self before engaging more fully in personal relationships due to previous patterns of adapting the self and the dangers associated with this:

> *I don't think I have my own identity yet. I think I'm creating it and building it now, so whenever I'm in situations, I have to be really careful that I don't just morph myself into who they want me to be or who I perceive that they want me to be.* (Sara).

Elizabeth experienced healthier relationships as a learning opportunity about her self-worth. She spoke about the power of relational healing in complex trauma building a sense of internal strength where her own capacity was limited:

> *…when you've gone through so much crap, having people that love you the way you are is so much more important than just trying to love yourself, because you've got all of those things in the back of your head of these people did not like me the way I am. So having people that counteract that and give you more ability to fight internally, then maybe there is something to you that is more important*.

Green described the power of their intimate relationship, providing an unfamiliar sense of love without conditions. This seemed to fulfil a longstanding unmet need for love and acceptance whilst eliciting grief: *'I guess it's almost sad that… I have this incredible love now that I never had experienced beforehand from anyone… I can't stop appreciating it.. it's almost foreign...'*.

Discussion

The study aimed to explore the impact of complex trauma on participants' personal relationships. Ten semi-structured interviews were conducted with adult service users recruited from NHS Community Mental Health Teams. IPA was used to develop four Group Experiential Themes and related subthemes: (1) The void of attachment needs; (2) Inner

narratives that shape our relationships; (3) Challenges in relating with others; (4) Change and growth.

All participants described early attachment-related trauma, which impacted their personal relationships. Traumatic experiences likely impeded the development of a secure base in childhood (Bowlby, 1988), creating voids through the laceration or dismissal of attachment needs, leading to a subsequent activation of the attachment system and fears in personal relationships as adults (Cloitre, 2021; Mikulincer et al., 2006). Such fears manifested in several ways. For example, chronic attachment anxiety perpetuated perceived distress in relationships (Ogle et al., 2016) and led to patterns of dependence and maintaining proximity to support in regulating intense emotions. Such behaviours inhibited balance within relationships, perpetuating fears of abandonment, and likely created challenges for others due to the responsibilities placed upon them (Guan et al., 2025). Additionally, attachment challenges led to fundamental difficulties establishing trust and safety within personal relationships, creating distance and perpetuating mistrust (Haslam & Stratameyer, 2016). The depth of dehumanisation of the self and others, as expressed by Sara, is a stark indication of the level of disconnection that can manifest in personal relationships due to the impact of complex trauma on attachment patterns (Haslam & Stratameyer, 2016).

Early attachment experiences were likely associated with the development of negative self-beliefs reported in the study, relating to worthlessness and shame, due to a disruption of the internal working model of relationships. The extent of these afflictions can be understood through participants' internalised narratives that were defined by trauma-related beliefs. Inner narratives relating to ongoing fears, vulnerabilities, and self-doubt further perpetuated feelings of unworthiness in personal relationships. Such findings align with literature demonstrating that complex trauma can profoundly distort identity, leading to maladaptive schemas that influence relational perception and behaviour (Herman, 1992; Pearlman &

Courtois, 2005; Cloitre et al., 2014). Additionally, the findings in Theme 2 indicated that trauma-shaped core beliefs were particularly resistant to change, even within the context of supportive and healthy relationships, highlighting the complex impact of internalised trauma-related cognitions on personal relationships (Dorahy et al., 2013; Karatzias et al., 2019).

The findings suggest a connection between relational strategies/dynamics, emotion regulation, and relational risk. Participants described patterns of appeasing behaviours and silencing their needs in personal relationships. These behaviours may be understood as attempts to maintain attachment security and safety, where individuals with complex trauma develop adaptive survival strategies in response to early experiences of abuse, neglect, or unpredictable caregiving (Bailey et al., 2023; Rayome et al., 2010). Such patterns may emerge from maladaptive schemas that develop because of early trauma, perpetuating drives to seek approval, avoid punishment, and maintain emotional connection (Young et al., 2003). Although these strategies may have helped regulate arousal and preserve connection, they also reduced opportunities for self-expression and authentic relating, therefore exacerbating boundary difficulties. Such challenges can undermine equity and self-agency in relationships, further impacting an already vulnerable sense of identity (Luyten et al., 2020) and increasing susceptibility to interpersonal exploitation or abuse. The findings illustrate the phenomenon of repetition compulsion, where participants unconsciously recreated relational dynamics associated with early attachment experiences (Lazar & Erlich, 1996), likely seeking safety in relationships. Repetition compulsion perpetuates cycles of victimisation or diminishment of personal needs in relationships and highlights unconscious mechanisms through which complex trauma influences relational functioning in adulthood (Lazar & Erlich, 1996). Importantly, awareness of these dynamics was associated with increased insight, suggesting the potential for relational learning and attempts to restructure attachment patterns.

Distance and avoidance behaviours, described in *self-preservation and protection*, further exemplified strategies for seeking safety when navigating perceived dangers in relationships (Bartholomew, 1990; Crittenden, 1999; Fraley & Shaver, 2000). Patterns of mistrust and avoidance align with established understandings of the interpersonal impact of complex trauma and highlights the role of fear characterising engagement in personal relationships. Avoidance, emotional distancing, and withdrawal represent coping strategies that protect individuals from perceived threats and resulting fears. However, these strategies also restrict opportunities for closeness and support (Pearlman & Courtois, 2005). The accounts illustrate how difficulties trusting others, whether through interpreting benign gestures with suspicion or withdrawing from relationships, reflect hypervigilance and the manifestations of insecure attachment patterns (Mikulincer & Shaver, 2016). There were also indications of a desire to negotiate trust despite the fear of betrayal, and reframing hypervigilance as a protective measure. These findings highlight ambivalence in trauma-related relational patterns where mistrust can limit and, in some contexts, support adaptive decision-making in personal relationships.

Communication difficulties were reflected in individuals frequently experiencing relational interactions as characterised by danger, leading to reactive or passive communication patterns resulting from fear (Herman, 1992). Over time, perceived dangers maintain hypervigilance, fear of conflict, or difficulties expressing needs, as attempts to communicate authentically may feel unsafe (Herman, 1992). Misunderstandings, conflict, and relational withdrawal were frequent consequences of communication difficulties in personal relationships due to the long-term relational impacts of complex trauma shaping expectations and interpretation of others' behaviour (Lazar & Erlich, 1996; Smith & Charura, 2024). Additionally, strong emotional reactions were often triggered by seemingly benign interactions, leading to conflict and discord within relationships. These responses usually

occur in people with complex trauma due to heightened sensitivity of the nervous system, which leads individuals to react as though traumatic experiences are recurring, leading to withdrawal, conflict, or emotional shutdown (Nestgaard Rod & Schmidt, 2021; Nieuwenhove & Meganck, 2019; Pearlman & Courtois, 2005). These reactions are usually linked to the internalisation of insecure attachment patterns and difficulties with emotion regulation that are pervasive in complex trauma (Riggs, 2010), further impacting trust, intimacy, effective communication, and creating further distance where others may become fearful of their reactions (Riggs, 2010).

Supportive family environments are often regarded as central to recovery from trauma, providing a foundation for safety, trust, and relational repair (Herman, 1992, 1997). However, the findings of this study indicate that such support was largely absent, as many family relationships were marked by conflict, estrangement, or abuse. In the absence of these protective structures, participants developed personal relationships that provided emotional safety and belonging. Consistent with previous research, close, trusting relationships offered opportunities for individuals to re-establish security in themselves and others, supporting psychological, emotional, and relational healing (Figley & Figley, 2009). Some connections were characterised by shared experiences of trauma, mental health difficulties, or experiences of marginalisation, which appeared to build connection and security. This resonates with work highlighting the role of community and peer connection in buffering against the relational disruptions caused by trauma (Herman, 1992; Karatzias et al., 2022). Trust and safety were not consistently experienced across relationships. While some participants established security in longstanding intimate relationships, others continued to experience significant difficulties in forming or sustaining new connections, reflecting the enduring influence of attachment disruptions and relational mistrust that characterise complex trauma (Pearlman & Courtois, 2005). These findings suggest that relational recovery is highly

variable and highlight the complex relationship between attachment histories and opportunities for relational growth.

The findings suggest that experiences of personal and relational change were significant, characterised by increased hope for the future, highlighting the central role of relationships in recovery. Such changes are consistent with research emphasising the importance of relational connectedness and social support in post-trauma adaptation (Herman, 1992). Greater autonomy was described through improved emotion regulation and enhanced reflective capacity on the complexity of complex trauma, which facilitated healthier relational dynamics. Considering that many participants had accessed therapy or mental health support, these transformations may reflect the impact of therapeutic interventions. This is because trauma-focussed interventions support the development of positive attachment representations and adaptive interpersonal schemas, thereby improving relational growth (Karatzias et al., 2019; Pearlman & Courtois, 2005). The development of personal growth, which manifests in increased self-security, clearer relational boundaries, and greater trust, aligns with literature on post-traumatic growth, which emphasises positive psychological change and strengthened interpersonal functioning in the aftermath of trauma (Tedeschi & Calhoun, 2004). Therefore, these findings characterise the interplay between personal development and relational recovery, highlighting the potential for individuals with complex trauma to rebuild safety, trust, and connection in their personal relationships.

Research Implications

Subsequent research may benefit from recruiting more diverse samples to develop an understanding of the ways that complex trauma affects personal relationships across cultural, socioeconomic, gender, and age demographics. Longitudinal studies could explore changes in relational dynamics, attachment challenges, and interpersonal functioning over time, offering

deeper insight into healing and growth. It may also be helpful to explore experience within specific types of personal relationships. Studies that investigate relational growth, including safe relational environments, modelling of secure attachment, and effective rupture-repair processes, would help us to understand how individuals with complex trauma cultivate healthier and more adaptive relationship patterns. Finally, further research should explore the narratives of those who engage in personal relationships with individuals with complex trauma difficulties to fully illuminate the breadth of experience within relational systems.

Clinical Implications

This research indicates that people with complex trauma experience a multifaceted array of difficulties within their personal relationships. Clinical support to recognise the impact of trauma and abuse on attachment and relational patterns, and the internal processes that manifest as a result, is key in developing understanding for service users. Clinicians should remain open to any potential implications that impacted relational patterns may create between service users and professionals. Therapeutic relationships should recognise that fear is central to relational difficulties in complex trauma. Therefore, supporting people to regulate their fears is of fundamental importance in the context of an attachment-based relationship that builds safety and trust over time.

Strengths and limitations

A key strength of this research was representing the voices of people who have experienced abuse and oppression, reporting narratives that are underrepresented in the literature. There are few studies qualitatively exploring the experiences and meanings of people with complex trauma difficulties, and this study was valuable in building this knowledge. Another strength of the study was the incorporation of the IPA methodology,

which captured depth and detail within the data, based on the richness of experience and meaning.

The study has several limitations. The selection of participants was assessed by service professionals, in absence of the primary author. This process likely involved a degree of subjectivity that was beyond insights from the primary author and may have implications regarding who participated**.** One male participant took part, which may imply an underrepresentation of male experience within the research. This seems congruent with the higher proportion of females in complex trauma research and clinical settings. An opposing critique of this position is that diversity was represented in the sample relating to gender. However, these matters may raise considerations regarding sex and gender that are beyond the scope of this paper and will be explored further in the critical discussion. Another limitation is that all participants were receiving services from CMHTs, and some had current or previous involvement in therapy. This may have enhanced the reflective capacity of participants, leading to well-formed constructions of their experiences. It is likely that research with a different population, not utilising the support of mental health services, may have yielded different results.

Another limitation was imposed by the broad and ambiguous conceptualisation of complex trauma as reflected in the literature. The inclusion and exclusion criteria aligned with this conceptualisation to recruit an appropriate sample and remain open to a wider range of traumas. During interview, all participants disclosed experiences of complex childhood trauma relating to caregiving and interpersonal relationships. Therefore, the voices of those who experience complex trauma because of experiences of war, slavery, or human trafficking are not represented in this research, and results should be treated with caution in generalising findings to other complex trauma subtypes.

Conclusion

This study aimed to explore narratives and experiences on the impact of complex trauma on personal relationships. Attachment difficulties, negative beliefs, unhelpful dynamics, avoidance and mistrust, problematic communication, and managing triggers were reported to impact personal relationships in unhelpful ways. Findings indicated that the experience of being traumatised within early attachment relationships created significant challenges in personal relationships, often due to the continued manifestation of abuse and exploitation, or even when safe, ongoing feelings of fear and mistrust in others. The study highlighted that positive changes both within relationships and individually were supported through reparative relational experiences, leading to profound shifts in self-identity and the capacity to communicate and relate with others. The findings suggest that relationships are central within the aetiology and maintenance of complex trauma, indicating the pervasive nature of impairments in relational functioning. The study also highlights the importance of personal relationships in healing from complex trauma. Attachment-based approaches and an understanding of relationships when supporting individuals in therapy are considered fundamental in the treatment of individuals with complex trauma difficulties.

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Chapter 5: Additional Methodology Chapter

Chapter 5 – Additional Methodology Chapter

This chapter provides additional information regarding the methodology and design of the empirical paper. Further insights into the philosophical underpinnings of the research and Interpretive Phenomenological Analysis are discussed. Reflexivity and quality processes are described.

Ontology and Epistemology

It is important for researchers to consider their own ontological and epistemological positions within research. This is because these perspectives conceptualise how researchers understand the world and what counts as valid knowledge, influencing the approaches taken and shaping the design of studies. Crotty (1998) argues that clarity about these positions ensures consistency between research questions, methodology, and methods. Explicit awareness and discussion of these positions support maintaining the internal logic of research (Guba & Lincoln, 1994), strengthening reflexivity and trustworthiness, and guiding the interpretation of findings (Denzin & Lincoln, 2011; Scotland, 2012).

Ontology refers to assumptions about the nature of reality, addressing questions of what exists and how it can be understood (Denzin & Lincoln, 2011; Guba, 1990). It can be positioned on a spectrum ranging from realism, which assumes a single measurable reality (Clarke & Braun, 2013), to relativism, which views reality as multiple and socially constructed (Guba & Lincoln, 1994). In qualitative research exploring complex trauma and relationships, adopting a critical realist ontological stance is particularly useful (Fletcher, 2016). This perspective assumes that while an external reality exists independently of human perception, individuals engage with reality through subjective meanings that shape their lived experiences. Within the study, this position supported the understanding that participants' accounts reflected difficulties caused by real-life complex trauma events such as abuse and

mistreatment. Additionally, experiences and narratives were shaped by personal meanings and sociocultural discourses and contexts (Fletcher, 2016). This position also proposes that to understand acts of abuse or mistreatment from a purely constructivist position (as indicated through a relativist ontology), this would further perpetuate invalidation of the reality of participants' experiences.

The critical realist position was supported by an interpretive epistemology. Epistemology outlines how knowledge is understood and constructed, focusing on individuals' interpretations and the way people make sense of their experiences (Denzin & Lincoln, 2005). In an interpretivist framework, the relationship between researcher and participant is central, as knowledge is co-constructed through dialogue and reflexive engagement (Crotty, 1998; Denzin & Lincoln, 2011). From an interpretivist epistemological stance, knowledge is not discovered as objective truth but is co-constructed through the interaction between researcher and participant. This epistemological stance encouraged the exploration of the nuanced, lived realities of participants' relationships in a way that was sensitive, contextually grounded, and interpretive.

The role of the primary author within this study was to engage reflexively with participants' narratives, acknowledging the double hermeneutic (Smith et al., 2009), where participants made sense of their relational experiences and the researcher interpreted individuals' narratives and meanings. This approach positioned participants as active agents in the research process. Their insights were not considered simply as data, but rather rich accounts that required empathetic interpretive engagement. An interpretivist epistemology enabled the study to highlight participants' subjective perspectives while recognising the primary author's own influence in shaping the knowledge produced (Denzin & Lincoln, 2011). This approach informed data collection, whereby the primary author used prompts and further inquiry to make sense of participants' interpretations, to ensure that the double

hermeneutic was not applied against narratives and experiences that seemed vague or incomplete. The primary author also considered their own lived experience of complex trauma as shaping a lens through which participants' narratives were interpreted. This brought into consciousness the primary author's experiential awareness, with the intention of not imposing ideas and beliefs, allowing for the emergence of individual experience and meaning, grounded in participants' accounts, before being aided by reflexive interpretation.

Ethical Considerations

Potential for Distress

There was potential for participants to experience distress because of discussing difficult experiences and topics during the interview. As a clinician with previous experience working with individuals impacted by complex trauma difficulties in secondary care mental health services, the primary author maintained awareness of the safety of participants through the creation of a safe interview space, with gentle shared dialogue, informed consent, and appropriate debriefing. The topic guide was designed with open-ended questions, which allowed the interview to be conducted in a flexible way that was comfortable for participants. Participants were reassured that in the event of experiencing distress, opportunities would be given to cease the interview, take a break from the process, discuss a different topic/question, or continue in a way that felt safer. At the end of the interviews, participants were debriefed by the researcher and additional support for signposting was indicated on the Debrief Form (Appendix I). Participants were encouraged to ask questions and share their experiences of the interaction. They were signposted to their allocated care coordinator/duty team/General Practitioner for further support if needed. One participant was signposted to their Care Coordinator due to an expression regarding risk to self during the interview. Their needs were responded to promptly by the community mental health team.

Consent

During routine appointments or over the telephone, service professionals within community mental health teams gained consent from participants to be contacted by the primary author. This took place after the participant information sheet had been shared (Appendix E). Consent was demonstrated through completion of the consent to contact form (Appendix F). Alternatively, participants evidenced consent through emailing the primary author directly. At the beginning of the interviews, participants were given the opportunity to ask further questions and completed the informed consent form (Appendix G). There was no coercion from community mental health professionals or the primary author during consent processes. Participants were assured that non-participation would not impact their mental health treatment.

Confidentiality

Participants were informed that the information shared during the interview process would be held confidentially, except in cases where issues regarding risk to themselves or others emerged. Confidentiality considerations were outlined in the participant information sheet and informed consent form. All identifying information was removed to protect participants' anonymity, and the names of people and places were changed. No breaches of confidentiality occurred during the research process.

Data Protection

General Data Protection Regulations and UEA policy were adhered to in the secure storage of data. A Dictaphone was obtained from the university and used to record the interviews. Virtual interviews were recorded on MS Teams. The recordings were uploaded onto the UEA secure encrypted network drive and deleted from the Dictaphone. Transcription was carried out by the researcher using NVivo software. Narratives were

documented verbatim. Transcripts were manually checked by the researcher and stored on the university's encrypted network drive, after which time, interview recordings were deleted. Personal identifying information of participants (consent forms) was scanned and uploaded onto the UEA encrypted network drive, stored in a separate folder to the interview transcripts, with access solely permitted to the research team. Hard copies were destroyed. A password-protected phone stored participants' initials and contact information. The sim card for this phone was cancelled two weeks after the last interview took place, with all participants continuing to hold the email contact of the primary author. All identifying information will be deleted at the end of the research project (3-6 months after final thesis submission). Interview data will be held for up to 10 years as per GDPR requirements.

Analysis

Interpretive Phenomenological Analysis (IPA) was selected as the research methodology for the study. IPA seeks to understand an individual's lived experiences and provides an account underpinned by phenomenology (the philosophy of experience), hermeneutics (the interpretation of language), and idiography (relating to something concrete, individual, or unique) (Smith & Nizza, 2022). In accordance with the interpretive epistemological position, the research embraced the understanding that individuals were situated within contexts that shaped their experiences. The philosophy of experience proposes that the way we situate ourselves and experience the world is aided by grounding in the personal meanings and resources, including relationships, that are available to us (Smith et al., 2009). It accounts for the ways that individuals' understandings of their relational worlds are personal, shaped by experience and memory, and the meanings they hold, which were key in this research.

IPA uses exploration, description, interpretation, and situating to understand how individuals make sense of their experiences (Smith et al., 2009). Heidegger (1962) emphasises that the development of understanding is always interpretive. The approach uses a process of double hermeneutics, which involves active interpretation by the researcher to understand the ways that people make sense of their experiences (Smith et al., 2009). Fundamentally, IPA serves to create an interpretation whereby the researcher is "making sense of the participant trying to make sense of their personal and social world" (Smith, 2004, p40).

The idiographic focus of IPA is reflected in its aim to provide a rich, in-depth exploration of individual experiences. This differs from nomothetic approaches, which seek to identify patterns and make predictions about behaviour, based on data from large groups of people and using quantitative methods (Smith, 2004; Smith et al., 1995). Through the exploration of the particular rather than the general, IPA facilitates a detailed, contextually grounded understanding, allowing for nuanced and comprehensive insights into an individual's lived experience.

Analysis Process

The researcher conducted the analysis using the principles of IPA, where individual transcripts were viewed as discrete individual cases (Larkin & Thompson, 2012; Smith et al., 2009). It is noted that there is no prescribed manner in which IPA should be conducted. The process is both iterative and inductive and can be conducted flexibly. However, Smith (2021) outlines a six-step approach to aid IPA, which is emphasised as particularly helpful for first-time researchers using this approach:

1. Reading and rereading

The primary author became immersed in the data by reading and re-reading the interview transcripts and listening to the audio recordings. This process supported the primary author to become familiar with the content and context of participants' accounts, developing a deeper understanding of their relational worlds. Listening to the audio recordings added richness to this process as it allowed the primary author to capture emotion, tone of voice, and depth of expression within the narratives, which may have been lost if not revisited during the re-reading phase. The primary author noted reflections and assumptions during this phase, enhancing awareness of their own interpretations at an early stage. This led the primary author to begin the process of 'bracketting off' experiences and beliefs, with the intention of remaining focussed on the data to reduce the risk of misrepresenting participants' experiences and meanings.

2. Developing annotations and memos

During this phase of the analysis, detailed and free-written notes were made on the transcripts using the annotation function within NVivo, enhancing familiarisation with the data and beginning the interpretive process. The annotations were made across three levels: descriptive (describing the content of the narrative), linguistic (noting participants' use of language), and conceptual (interpreting and critiquing the data). This stage involved identifying significant statements in the transcripts..

3. Developing Personal Experiential Statements

From the initial annotations, the primary author developed Personal Experiential Statements (PESs) that captured the essence of the participants' experiences. The annotations within phase two supported this process, encouraging the primary author to focus on chunks within the transcript, whilst maintaining a wider awareness of what had been learnt from familiarisation with the narrative as a whole. This aspect of the analysis formed part of the double hermeneutic within IPA, where the primary author interpreted

chunks of data in relation to the whole whilst considering the whole in the context of these discrete parts. The primary author made wider interpretations during this stage, assigning names to PESs and integrating chunks of text into those where they converged. Many PESs stood alone during this stage and some integrated chunks of the narrative that were clearly similar. The PESs formed the building blocks for understanding the phenomenology under investigation and informed the next phase of theme development.

4. Developing Personal Experiential Themes

During this phase of the analysis, the primary author used the interpretive process to develop Personal Experiential Themes (PETs), examining the PESs to identify patterns and relationships, clustering those together that related to form a PET. This stage involved clustering themes into higher-order categories that reflected broader aspects of the experience. Some PETs contained subthemes that exemplified the complexity and nuance within the data. PETs were refined and less relevant PES's not included, as the analysis developed.

5. Moving to the Next Case

Once the PETs had been developed, the analysis proceeded to the next participant's transcript, repeating the process of reading, making annotations, and developing PESs and PETs. Each case was treated individually to maintain the idiographic focus of IPA, where the primary author attempted to 'bracket off' the previous participant's account.

6. Developing Group Experiential Themes

After analysing each case individually, the primary author searched for patterns and commonalities across all participant transcripts. This stage involved synthesising the findings to draw overarching conclusions about the shared experiences of the participants, represented in the development of Group Experiential Themes (GETs). During this stage,

it was helpful to recognise that concepts could be represented across multiple accounts within the data, with GETs being constructed in a way that represented these commonalities relating to experience, when they converged and diverged in similar areas. Where appropriate, subthemes were developed.

For examples of Personal Experiential Theme development and commentary, see Appendix J. For an example of Group Experiential Theme development, see Appendix K.

Reflexivity

The process of reflection is firmly integrated within IPA to focus on the specific phenomenon, associated thoughts, values, goals, and meanings, and to develop awareness of subjective experiences and bring them into consciousness (Husserl, 1927). Reflexivity developed an awareness of the impact of personal experience and biases, and a reflective diary was used throughout the research process to record personal reflections, observations, learning, development, and knowledge, assisting with interpretation. Recording in the reflective diary ensured that reflexivity and transparency were maintained (Biggerstaff & Thompson, 2008). Other mechanisms were available to the researcher to enhance reflexivity throughout the study, including research supervision and personal reflection time. Two reflective diary excerpts from the interview content are detailed below and provide an insight into the primary author's reflective processes that took place immediately after the interviews. These processes thereby influenced interpretation of the data:

1. **Example reflective journal entry post interview for Green:**

Green is a resilient young person. Their experience of trauma is layered - through direct abuse, the controlling nature of the family and doctrine, and the manipulation they experienced within family relationships. I can see Green's conflict and struggles in making sense of their trauma, the losses they have experienced, and perceive dialectics of pain and

healing relating to past and present relationships, which emphasise the complexity of their difficulties in personal relationships. There is something childlike and innocent in their nature, which made me want to provide care and support. I became aware of this during the interview and used this awareness to convey empathy and understanding whilst remaining focussed on the process of exploration of their experiences…

Green started by focussing on retrospective experiences as a child and we explored these to set the foundations before moving into the present, in line with Green's needs and comfort. I was struck about their ability to understand what they need (community and relationships) and reach for this, indicating strength and resilience. The newly formed group of friends has been instrumental in their healing. However, the relationships and friendships continue to trigger them, indicating the impact of past experiences of abuse and mistreatment on their relationships and the pervasive impact this continues to have…

I found this interview challenging due to the intensity of the abuse that was discussed. It brought up difficult feelings for me as a researcher and individual, holding the darkness of Green's narrative and experiences. I will be discussing further in research supervision.

2. **Example reflective journal entry post interview for Mary:**

Mary's friendships seem to be based on a mutual level of understanding, where they are bonded by having similar difficulties and not judging each other for their failures or difficulties - there is acceptance within this community and this is something that Mary seems to value very much. She lacked detail or personal introspection at times and it sometimes felt that despite my efforts, creating further insight and depth was challenging. It seemed like Mary could be quite outwardly focussed, perhaps due to her desire to try and make sense of her experiences in the context of her social world, but also likely impacted by her desire of 'trying to get everything out at once'. This may highlight some discomfort or uncertainty

within the participant/interviewer relationship. I also wonder if the outward focus accounted for Mary's challenges with identity. Mary talks about 'selling sand to the arabs' and 'wiping the slate clean' and starting again, like a new identity is established as she makes her way through life - I wonder if this detracts her from connecting with herself in a more authentic way, leading to less interpretations from her in the interview. I'm mindful that this is my interpretation. This adaptation could relate to the impact of complex trauma, and the development of survival behaviours, in turn impacting her personal relationships.

Transparency and Quality

Yardley (2000) recommended four key principles that the primary author considered in assessing the validity and quality of qualitative research: sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance. To ensure that these processes are explicit, they are documented in Table 1.

Table 1.

Transparency and Quality (Yardley, 2000)

Guideline	How principles were met
Sensitivity to context	• The primary author has lived experience of complex trauma. Additionally, all members of the research team had experience working with individuals with complex trauma difficulties. This served to develop understanding in the context within which participants' narratives were experienced. • The primary author had read widely on complex trauma and its relational impacts. • The primary author kept a reflective journal throughout the research process to bring into consciousness their own biases and beliefs. • The method of recruitment, via gatekeepers and service professionals enhanced sensitivity to participants' contexts, where they were able to talk about the research with a

	trusted person before giving consent and speaking with the primary author. • Discussion with the primary author prior to meeting for the interview helped in developing a rapport and reduced potential power differences between both parties. • During the interviews, the primary author asked for clarification on narratives that seemed unclear, to accurately reflect participants' experiences and meanings. • The views of the research team on the analytic process and study findings were sought consistently during supervision. • Participants were given the choice over where the interviews were held: online or in person. They also had a choice of location if interviews were conducted in person. • Participants were offered the opportunity to take breaks when needed and to guide the interview process according to their comfort. • The primary author remained attuned to participants' emotional wellbeing throughout the interviews.
Commitment and rigour	• Participants were recruited using purposive sampling which is suitable for IPA studies. • All aspects of ethical processes were applied consistently. • In the early stages and throughout the research process, exploration of the topic area and associations with the evidence base were discussed in supervision. • Participant accounts were discussed in research supervision, and interpretations were considered throughout the data collection and analysis stages. • The primary supervisor read widely on the process of Interpretive Phenomenological Analysis and sought to engage in a rigorous analytical process, ensuring that all stages were conducted robustly.
Transparency and coherence	• Research summaries were offered to all participants who took part in the study. • To support transparency in the analysis process, accurate transcripts were imported into NVivo, and all stages of the IPA process were recorded in separate folders for each participant. A reflective diary was kept to document the primary author's assumptions, beliefs, and actions. Memos within NVivo were also used to reflect on the analysis process.

	• Through the reflexive engagement in research supervision and the primary author reading widely about methodological designs and types of analysis, IPA was considered the most appropriate approach for answering the research question. This was because IPA is a suitable framework for exploring experience, particularly in complex areas of interest. A phenomenological approach also seemed most appropriate for giving a voice to individuals who had experienced complex trauma.
Impact and importance	• The research demonstrated high impact and importance through exploring the narratives and experiences of individuals with complex trauma – voices which are underrepresented in research. • The importance of the study was further reflected by the marker of the initial research proposal. • The findings of the study have clinical importance within services as they provide deeper insights into the lived experiences of individuals with complex trauma within their relationships. This may support clinicians in developing their understanding, informing clinical practice. • The research starts to fill a knowledge gap in direct narratives and experiences relating to the impact of complex trauma on personal relationships.

Chapter 6: Critical Discussion

Chapter 5: Discussion and Critical Evaluation

This chapter presents the findings of the systematic review and empirical paper. Reflections on the research process will be explored. The findings of both papers will be considered jointly, and the strengths and limitations of the research will be critically evaluated. Finally, the clinical and research implications will be considered.

Summary of findings

The systematic review narratively synthesised twelve qualitative studies exploring therapeutic relationship qualities in the context of complex childhood trauma, identifying six overarching themes: The core foundations are fundamental, From chaos to coherence, Therapists with courage, We are in this together, Boundaries, and A new attachment relationship. Across studies, trust, safety, and human qualities of the therapist emerged as essential foundations; without these, therapy was perceived as ineffective or sometimes ruptured. The conditions were improved by therapists' capacity to normalise clients' experiences, challenging internalised narratives of worthlessness or defectiveness. Courage was required from therapists to engage with painful material and sometimes extend beyond conventional therapeutic limits to demonstrate care and consistency. Such efforts were balanced by the need for flexible yet clear boundaries, ensuring clients felt both secure and understood. Equity in therapeutic relationships served to address power imbalances and supported clients' sense of agency. Most critically, the therapeutic relationship was experienced as a new attachment, providing corrective relational experiences characterised by care and non-judgement, and a reparative familial quality. The development of the attachment relationship in therapy with individuals with complex childhood trauma demonstrated that relational modelling, safety, and security were integral to therapeutic change.

The empirical paper explored the lived experiences of ten participants regarding the impact of complex trauma on their personal relationships, analysed using Interpretive Phenomenological Analysis (Smith et al., 2021). Four group experiential themes with related subthemes were developed: The void of attachment needs, Inner narratives that shape our relationships, Challenges in relating with others (subthemes: dynamics in relationships, self-preservation and protection, struggles with communication, and triggers in relationships), and Change and growth (subthemes: small circles where we feel secure and learning through relationships). Findings highlighted significant relational difficulties that were rooted in disrupted early attachments and experiences of childhood adversity. Participants described cycles of dependency and avoidance in personal relationships, reflecting attempts to manage fear and maintain safety. Experiencing complex trauma created ongoing vulnerability in personal relationships, sometimes leading to abusive or oppressive partnerships and friendships, which in turn exacerbated trauma-related difficulties, deepening relational and individual maladaptive cycles. Appeasement and boundary difficulties, and communication struggles often perpetuated the prioritisation of others' needs in relationships and impacted participants' sense of identity and agency. For some participants, complex trauma difficulties led to triggers heightening aggression or rage responses, usually linked to emotional regulation challenges. The study highlighted the pervasive influence of complex trauma on attachment systems and personal relationships across the lifespan. However, participants also described narratives of resilience, growth, and relational healing. The development of healthier personal relationships in adulthood provided opportunities for corrective experiences, demonstrating that, even in the context of ongoing difficulties, the experience of adaptive personal relationships built safety, a stronger sense of identity, and a sense of hope about the future.

Researcher Reflections

Background to the study

My background includes direct lived experience of complex trauma, originating in childhood. I have also worked in several clinical roles supporting individuals with complex trauma difficulties throughout my career. This experience increased my awareness of the challenges that people with complex trauma encounter in navigating relationships, both personal and professional, and the ongoing impact that relationships exert upon wellbeing over the life course. Husserl's observation that relationships are fundamental to the human experience aligns with this perspective (Husserl, 1962). I recognised that developing an understanding of the impact of complex trauma difficulties on personal and professional relationships was unlikely to be captured by quantitative investigation, as the nuances and depth of experience would likely not be interpreted or understood in sufficient depth through this methodology. Additionally, a purely realist approach that would align more closely with the quantitative method countered my understanding of the nature of reality and the ways we develop knowledge. This shaped the conceptualisation of both studies, using qualitative methods to explore narratives and meanings, and accounted for the incorporation of interpretation and construction in understanding experience. These underpinnings were further guided by insights from the research literature, which highlighted the need for qualitative approaches to give a voice to people with complex trauma, whose narratives were not adequately represented in the research sphere (Melton et al., 2020).

Previous clinical experience informing the study

In clinical roles, I often felt that there were harsh narratives within services and amongst professionals, bestowed upon people with complex trauma difficulties. This was particularly evident if individuals presented with 'personality disorder-related challenges', as

discussed in the introduction to the thesis. Professionals often expressed frustrations and sometimes damning critiques regarding the associated behaviours and general complexity in individuals who experienced complex trauma, usually because of service users' heightened emotional and relational needs influencing transference and countertransference within these relationships (Pearlman & Courtois, 2005). I perceived a lack of understanding regarding the ways that individuals' mental health challenges were associated with relational experiences of abuse or mistreatment in early life, which felt somewhat jarring in the context of my own experience.

Lived experience informing the research

Having lived experience of complex trauma fundamentally shaped the lens through which I understood relational challenges, informing the research process. In the earlier stages of the study, when developing the protocol and applying for ethical approval, my central intention was to simultaneously illuminate the experiences of participants whilst taking mindful and measured action to preserve their wellbeing throughout recruitment, interview, and beyond. I consider that having lived experience supported these processes due to enhanced empathy and understanding towards participants' wellbeing and their safety needs when taking part in the research.

During recruitment and interviews, I felt that I was able to develop positive and meaningful relationships with participants. I was conscious of my position as a researcher and considered the implications for power differentials in the relationship between myself and those taking part in the study. Empathic caring, embodiment of human qualities such as genuineness and appropriate humour, and serving to empower participants, were key attributes throughout this process. Interestingly, these elements mirrored some of the findings from both studies regarding individuals' needs within relationships. However, I was also

mindful that these were transitory, purposeful exchanges. Ultimately, there was a need for me to access information from participants. This raised further moral dilemmas, where the ethical attributes I conveyed may have concealed power differences in the researcher/researched relationship (Brinkmann & Kvale, 2005). This led to further reflection on the notion of trust, as I, in my position as a researcher, depended on the trust of participants to gain access to their narratives and experiences. This is where my lived experience became my greatest asset; informing my capacity to empathise and understand, and also through demonstrating a genuine and authentic interest, which supported engagement in the interviews (Råheim et al., 2016). Participants also communicated their own motivations for taking part, such as a desire to tell their stories to improve understanding and awareness of the complexities of living with complex trauma, and desires to formally contribute to the evidence base. Awareness of these elements led me to understand the mutuality within these relationships, which, although transitory, conveyed a sense of purpose on both sides of the dyad, thereby reducing power inequalities in the research process.

The experience of complex trauma leads to pronounced feelings of self-doubt, due to the impacts upon self-agency and identity (McCormack & Thomson, 2017). This led to intense deliberations at various stages regarding the validity, usefulness, and ethics of the empirical paper. Such fears were to be overcome by courageously becoming conscious of my position and experiential lens, remaining aware of the research's purpose and ethical considerations, and reflecting on how lived experience influenced the double hermeneutic, as emphasised within Interpretive Phenomenological Analysis. During the analysis phase of the empirical paper, I was mindful of my lens whilst remaining open to the narratives and meanings of participants. I did not seek to find the results that were developed or intend to make assumptions about the data. Themes were developed based on the convergence, patterns, and divergence that were clearly grounded in the narratives. However, the

experiential lens through which I viewed the data led to feelings of personal resonance and understanding at varying stages. This supported the selection of excerpts within the results section that highlighted the fundamental experience of participants. Such outcomes brought to life theoretical understandings that were depicted in the research literature.

When I began the analytic stage, I experienced a stark realisation of the nature of this time-consuming endeavour – that in doing justice to the participants' narratives and experiences, I would need time and a great deal of personal insight and energy to interpret the data well, carefully attempting not to impose my own ideas from experience or generalise between participants in the early stages. The process developed my understanding of participants' uniqueness as individuals within their own cultural contexts, despite their shared experiences relating to complex trauma. Attempts to represent the depth and variation within their experience were complex, and I found it challenging to 'let go' of data that did not quite fit. For example, many participants spoke in depth about traumatic experiences in childhood, which, although helpful in understanding context, were less relevant to the research question. Providing space for participants to explore these experiences deepened trust within the relationship, whilst giving opportunities for people to convey context, from which they could explore the impacts of complex trauma on their relationships with a greater sense of clarity. These reflections also deepened my insights into the importance of the first theme, 'the void of attachment needs', and the underpinnings of attachment-related challenges that were highlighted across other themes.

Learning on research processes

Many years before doctoral training, I had completed a masters level qualitative study using thematic analysis (Braun & Clarke, 2006), and I considered using this approach within the empirical paper. I had no prior experience of IPA. When considering the methodological

and analytic approach, I aligned with IPA because it allowed for a deeper exploration of participants' lived experiences and meaning-making processes in the context of complex trauma. I felt this was a more suitable approach than thematic analysis for this study. While thematic analysis could identify broad patterns across data, IPA seemed more adept at prioritising the nuanced, subjective, and relational aspects of experience, which are central to understanding the impact of trauma on personal relationships. The process of learning through the development of the study taught me a range of skills within this approach, which was an asset both to the study and in my development as a researcher. Similarly, I had never undertaken a systematic review. Engaging in this process felt daunting and overwhelming due to my unfamiliarity with this type of research. I learned valuable research skills through developing a protocol and refining a question, searching academic databases, screening literature, and critical evaluation. Undertaking two qualitative projects encouraged me to immerse myself in iterative processes in research, negotiating positions between focussing in-depth and standing back at varying stages. This aligned with the IPA approach of understanding constituent parts in the context of the whole and understanding the whole in relation to smaller selections of data.

Conceptualisation of complex trauma within the thesis

When I selected the thesis, the initial scope for the project was wide and based on 'Emotion Science as an Alternative to Diagnosis' (Howells, 2022). This created opportunities for me to shape the project in line with my own interests. The critical stance offered a useful foundation for considering the challenges in diagnosis and classification within complex trauma, aligning with my positioning as a researcher and clinician in questioning the structures imposed within society and services regarding the way we conceptualise and work with trauma-related mental health challenges. My position aligned strongly with an anti-diagnosis stance (Johnstone & Boyle, 2018), which informed recruitment for the empirical

paper and inclusion of studies in the systematic review, where both studies implemented inclusion according to experience. However, this also led to challenges in focussing the introduction of the empirical paper, where classifications and terms for complex trauma were broad, sometimes ambiguous, and encompassed a wide range of difficulties and aetiologies. It led to the development of inclusion criteria that were similarly broad, to enhance recruitment for the study and reflect the multifaceted range of traumas within childhood and across the life course that lead to the development of complex trauma difficulties. The sample for the empirical paper reflected the commonalities in research findings, where complex trauma events usually take place in childhood within caregiving relationships (Cook et al., 2005; Thain et al., 2024)

My learning throughout the empirical paper and from reading widely encouraged me to think more specifically about complex childhood trauma in the context of caregiving relationships and its effects on interpersonal attachments. This led me to adapt the approach within the systematic review. Discussions in supervision supported reflexivity in this process. As the systematic review was conducted after the empirical paper had been completed, but after an initial protocol had been published, I amended the inclusion and exclusion criteria to 'tighten up' the output of relevant research papers, with the intention of capturing views from a similar cohort of participants, those who had experienced complex childhood trauma. This supported the development of homogeneity in the data that assisted in the applicability of the findings to a more specific population. An iterative process of re-evaluating the studies that emerged in the searches was applied using a more focussed inclusion and exclusion criteria. This process of learning across the two studies forms the rationale for why the classifications of complex trauma are slightly different across the papers.

Supervision

Developing professional relationships with members of the supervisory team supported in managing the many hurdles associated with the research process, providing a wealth of expertise, support, and challenges at varying stages. With consideration to my own lived experience, I reflected on my ability to navigate trust and safety within these relationships, in a research process that felt both unfamiliar and daunting. Support from the research team assisted in the development of themes in the empirical paper through a mutually reflective process that enabled me to focus on the relevance of data in answering the research question. This also helped me to understand what data to 'let go of' when developing the final themes. When my primary supervisor left the university in the early part of 2025, there was a recalibration of these relationships and a shift in the way the research was supervised. The empirical paper was mostly complete by this time, and this change aligning with the shift in the research process, was well timed. The nature of supervision developed from immersing and reflecting on rich first-hand participant data to the completion of the systematic review and writing up. After some initial ambivalence about the supervisory change, I was able to reaffirm confidence in my position as a researcher with the support of my supervisor, which led to increased trust both in the supervisory relationship and in my abilities to conduct the systematic review.

Integrated Discussion

This thesis aimed to add to the body of qualitative literature that explores the impact of complex trauma on relationships. The findings of the systematic review and empirical study together emphasised the fundamental role of relationships in the development and recovery from complex trauma. There were patterns of convergence in the outcomes of the studies, which will be discussed.

In the empirical paper, participants described a void in their attachment needs due to early experiences of abuse/mistreatment with caregivers, impacting the internal working model of relationships and heightening relational fear (Mikulincer & Shaver, 2016). This led to feeling unsafe in personal relationships. The systematic review identified the importance of ameliorating relational fear in clients with complex childhood trauma within therapeutic relationships through providing corrective attachments, emphasising trust and safety as essential. Without the foundational qualities in the therapeutic relationship, therapy was described as ruptured or unhelpful (Dalenberg, 2004; McGregor et al., 2006). Similarly, in the empirical paper, a perceived lack of safety led to continued experiences of conflict, dependence, or avoidance within personal relationships. Fear and withdrawal were likely adaptive when there was an ongoing risk of abuse or harm. However, in healthy relationships, these strategies become counterintuitive to the development of interpersonal connection. This emphasises the function of therapeutic relationships in promoting safety and trust in the context of an ethically sound and attuned therapeutic dyad. Therapeutic relationships provide opportunities to address fear-based attachment behaviours in therapy processes and support individuals to develop a greater sense of self-agency and trust in navigating the complexities of personal relationships.

The void of attachment theme, as emphasised in the empirical paper, highlighted both the fundamental importance of attachment relationships in people's lives and the challenges in attachment relationships for individuals with complex trauma difficulties (Pearlman & Courtois, 2005). The systematic review builds upon these findings by emphasising the significance of rebuilding attachment relationships in a therapeutic context. This is consistent with recommendations from complex trauma therapy frameworks, which emphasise the key role of attachment in complex trauma in forming new healthier relational templates (Herman, 1992; Pearlman & Courtois, 2005), When considered together, the studies show that trauma-

related attachment difficulties impair personal relationships and create unique challenges within therapy, highlighting the importance of reparative attachment experiences and the amelioration of fear through developing trust and safety, in healing and recovery in personal and therapeutic relationships.

The theme *from chaos to coherence* in the systematic review aligned with the *inner narratives that shape our relationships* theme in the empirical paper. Participants described negative core beliefs that developed because of pervasive and repeated traumas from childhood in family contexts, leading to feelings of shame and low self-worth, perpetuating relational challenges (Dorahy et al., 2013; Herman, 1992). In the systematic review, the process of creating a sense of coherence through understanding, validating, and reframing provided therapists with opportunities to support clients in rebuilding inner narratives of defectiveness as a key function of ameliorating shame, enhancing therapeutic relationships. This was facilitated through therapists' careful communication of trauma-based knowledge and modelling adaptive relational experiences, in challenging deep-rooted beliefs of unworthiness or expectations of danger (Rogalla & Hash, 2024). The influence of reparative experiences on beliefs was further echoed within the empirical paper. In the *learning through relationships* theme, increasingly adaptive beliefs developed because of healthier attachment experiences and communication within personal relationships, providing corrective emotional experiences and opportunities for growth, which led to a shift in beliefs. Additionally, the value of normalising complex trauma experiences and relational difficulties, as emphasised within the systematic review, overlaps with the *challenges of relating with others* that participants reported in the empirical paper. This link highlights that processes of normalisation seek to improve understanding of the psychological, emotional, and relational trauma-related challenges that individuals experience, through providing insight into the context of the aetiology of such challenges.

The *challenges in relating with others* theme, as discussed in the empirical paper, exemplified the ongoing difficulties that individuals with complex trauma encounter in their personal relationships. Managing communication difficulties, adopting adaptive but often unhelpful survival-based strategies of withdrawal or appeasement, and negotiating triggers that elicited difficulties in emotion regulation were all key findings that demonstrated the magnitude of complexity that manifests in personal relationships. In the systematic review, some of these challenges were experienced in therapeutic relationships, highlighting the ways that such strategies were not solely rooted in one type of relationship, but rather reflected a wider pattern of difficulties that emerged through growing closeness and vulnerability. These findings emphasise the value of the theme *therapists with courage* in the systematic review, where the necessity of holding courage was essential in supporting individuals with complex childhood trauma with their difficulties. Additionally, courage was demonstrated within the empirical paper. Where participants indicated a commitment and ongoing drive to reflect, grow, and learn within relationships, in a context that had previously caused significant harm. Therefore, courage on the part of individuals with complex trauma and those in relationships with them (both personal and professional) is fundamental for creating understanding and experiencing adaptive relational experiences that support healing and growth.

Both studies considered the role of power and equity in the lives of individuals with complex trauma. In the empirical paper, participants described experiences of victimisation within their personal relationships that manifested as a consequence of maladaptive attachment-related trauma patterns originating in childhood. Their narratives indicated significant power imbalances within abusive or oppressive relationships as adults/young people (Conroy, 2014). Similar experiences were echoed by client participants in the systematic review. The power discord that manifests through traumatic experiences of abuse and mistreatment underpins the fundamental importance of promoting equity and agency in

therapeutic relationships (Tummala-Narra et al., 2012) and in personal relationships. In the *small circles where we feel secure* theme in the empirical paper, the value of shared experiences of trauma, mental health difficulties, and neurodiversity was experienced as promoting safety within personal relationships, likely due to the sense of equality and mutual understanding that was experienced. This relates further to findings from the systematic review that represented the shared venture in the therapeutic relationship, as discussed in the theme *we are in this together.* In creating a dyad that reflected a shared endeavour in the therapeutic process, clients felt a sense of equity and understanding. Both papers emphasise the importance of safety, agency, and mutual understanding within relationships, countering previous experiences of betrayal, exploitation, and harm, and reducing power inequalities, to provide new frameworks in relationships.

The systematic review identified relational qualities that characterise therapeutic relationships in complex childhood trauma, offering insights into the elements that are conducive to recovery. The empirical study demonstrated the depth of relational disruption and mental distress that people with complex trauma experience, providing a rationale for why these qualities in therapeutic relationships are imperative. When considered together, these findings highlight the tension and conflict that manifests within the relational lives of individuals with complex trauma difficulties. Where those who are most in need of secure attachments are often least equipped to establish them (Liotti, 2004), both personally and therapeutically. This reinforces the view that therapy for complex trauma must be conceptualised not solely as a psychological intervention but as a relational one, where boundaries, safety, and mutuality are central to recovery (Courtois & Ford, 2020). The fundamental importance of relational safety, boundaries, and repair across both clinical practice and lived experience emphasises that therapy is not only a treatment modality but a relational intervention in itself (Pearlman & Courtois, 2005)

The systematic review and empirical paper add to the growing body of literature in the complex trauma field, offering insights into the diverse array of challenges experienced by individuals with complex trauma within personal and therapeutic relationships. The studies create an understanding of the fundamental nature of personal and therapeutic relationships in providing an adaptive experience to counter the psychological, emotional, and relational aftermath of complex trauma. However, the research opens further questions about what individuals need from their relationships. The systematic review highlighted the important qualities of the therapeutic relationship, and the empirical paper emphasised healing and growth through personal relationships. Potentially, these findings could be considered more widely to assert that it is the nature of the close relationship itself, providing corrective experiences and opportunities for growth through safe vulnerability, rather than the function being solely attributed to personal or therapeutic relationships. However, both studies add narratives characterised by depth and meaning to support the real-life application and experience of working with individuals with complex trauma in the context of the realities of their lives, supporting evidence that adaptive relationships can buffer complex trauma's long-term impact (Charuvastra & Cloitre, 2008; Pearlman & Courtois, 2005).

Critical evaluation of strengths and limitations

The specific strengths and limitations of both studies were discussed within Chapters 2 and 4 of the Thesis Portfolio. This section aims to describe the wider strengths and limitations of the research.

In seeking the perspectives and experiences of adults within the systematic review and empirical paper, both studies implemented inclusion criteria recruiting adults over the age of 18 years. Within the empirical paper, there was variation in the age ranges of participants. When considering participants' experiences and meanings, generational and age-

related differences are likely not adequately interpreted. For example, older participants may have remained in abusive or unhelpful relationships for longer and had less access to trauma-informed mental health support to improve their understanding of complex trauma related challenges at an earlier age. This may be associated with sociocultural and time-specific practices influencing gender and family norms that discouraged leaving abusive relationships (Dobash & Dobash, 1992) and provided fewer protections against abusive family systems (Ferguson, 1997). Additionally, there was widespread stigma surrounding mental health help-seeking (Corrigan, 2004), limited availability of trauma-informed frameworks within services before the 1990s (Bloom, 1997; Herman, 1992), and dominant psychiatric models often pathologised psychological difficulties without acknowledging trauma as a central factor (Summerfield, 2001). These contextual factors may shape how older participants understood and described their experiences of trauma compared to younger participants, who may have experienced greater public awareness, policy changes, and access to trauma-informed care. Further research into the relational experiences of older populations with complex trauma may be useful to explore these challenges. Again, within the systematic review, these considerations were not addressed.

A strength of this thesis was in the process of recruiting participants and selecting studies according to the lived experience of complex trauma events and subsequent difficulties. This was important given the challenges associated with conceptualisation and diagnosis as noted within the studies and thesis introduction. Diagnosis is characterised by controversy in the trauma field due to the emphasis on individualised distress**,** potentially overlooking the social, relational, and trauma-related contexts that cause suffering (Boyle & Johnstone, 2014). Additionally, the medicalisation of mental health systems perpetuates the use of labels such as ‘disorder’, which contributes to pathologising normal responses to adverse experiences, like abuse, neglect, or systemic oppression, rather than acknowledging

them as understandable reactions to trauma (Bentall, 2010). Recruiting participants based on their experiences provided a helpful framework that moved beyond the limits of diagnosis and supported the exploration of narratives and perspectives relating to experience, which is consistent with IPA (Smith et al., 2021). The research did not recruit participants or studies by specific types of abuse, which reflected the widespread knowledge that multiple forms of abuse lead to complex trauma difficulties (Herman, 1992; Kliethermes et al., 2014; Newman et al., 1997). However, this may have led to missing unique patterns relating to trauma subtypes, which may have implications for the interpretation of results and findings of the studies.

The empirical paper demonstrated diversity in gender and sexual orientation differences across the sample. Diversity in the sample supported the representation of narratives from groups that have been further marginalised through their experience of minoritisation based on protected characteristics of gender and sexual orientation (Meyer, 2003). This is considered a strength of the research. However, further exploration of the impact of complex trauma on personal relationships in the context of diversity in gender identity and sexual orientation was not explicitly addressed in the findings. Previous studies indicate higher levels of attachment disorganisation and polyvictimisation in individuals who are gender diverse (Giovanardi et al., 2018). Additionally, individuals who are gay, lesbian, and bisexual experience higher rates of childhood maltreatment, interpersonal violence, and trauma (Roberts et al., 2010). These findings indicate that the impact of complex trauma upon relationships may be characterised by further complications for individuals in the LGBTQ+ community. When considering sex related differences, across both papers, there is an under-representation of male narratives and experiences regarding the impact of complex trauma on both personal and therapeutic relationships. This under-representation is reflected in the wider complex trauma literature and may highlight the unique challenges that males

encounter within personal and therapeutic relationships (Weetman et al., 2021; Yarrow & Churchill, 2009), likely associated with cultural expectations regarding strength and stigma in expressing vulnerability. This potentially has implications for males accessing mental health support and taking part in trauma-related research (Yarrow & Churchill, 2009).

The primary author developed the inclusion and exclusion criteria for the systematic review in collaboration with the research team through an iterative process of criteria development to support homogeneity within the data. This informed the selection of papers in an area characterised by ambiguity due to classification challenges. Grey literature was excluded due to the lack of peer review, potentially reducing the methodological rigour of included studies. However, excluding grey literature and unpublished research may have led to missing informative and potentially innovative findings from information sources not so easily accessed in the research sphere. Additionally, the systematic review focussed on talking therapies, encompassing a wide variety of therapies regardless of therapeutic modality. There could be differences in the way these approaches understand (depending on the theoretical framework) and work with individuals' experiences of trauma in therapeutic relationships. The systematic review also excluded body and movement-based therapies and therapies involving touch, which could have yielded interesting insights into the therapeutic relationship in therapies with individuals with complex trauma difficulties.

Clinical implications

Both studies highlight the importance of attachment relationships, both on a personal and professional level. Therapists working with complex trauma populations bear a significant responsibility considering the multifaceted and pervasive array of difficulties that individuals experience and present with in services. Particularly as such difficulties manifest within therapeutic relationships. Therapists working with complex trauma should provide a

safe, stabilising, and attuned relational environment, helping individuals to process traumatic experiences, build emotion regulation skills, and develop a new relational framework (Herman, 1992; Pearlman & Courtois, 2005). Additionally, therapists should focus on establishing trust, coregulating emotion, and supporting agency and equity**,** rather than solely focussing on the treatment of difficulties. These considerations highlight the importance of therapists' reflexivity on their own interpersonal qualities, such as being human, open, and consistent, and the ways these are conveyed in therapeutic relationships.

Balancing clients' needs within therapy processes is complex and likely presents challenges for therapists and professionals working with individuals with complex trauma. Therapists are developing a new attachment relationship with clients, which has ongoing implications for the way that boundaries are affirmed and managed within therapeutic work (Wallin, 2007). These matters may be subject to confusion, re-evaluation, and learning through the therapeutic process, particularly as the systematic review highlights somewhat conflicting needs within therapeutic relationships (such as having clear boundaries whilst being flexible). The findings suggest that a commitment to person-centred practice within therapeutic relationships may assist therapists in negotiating the intricacies of therapeutic encounters whilst developing trust and safety (Chouliara et al., 2024).

Therapeutic relationships may be subject to further influence from the therapist's own attachment patterns and heightened complexities through transference and countertransference processes within the relationship (Woodhouse et al., 2003). Therefore, reflexivity and effective supervision are key in navigating the complexities of such work. Additionally, these processes should support therapists in managing ruptures and therapy endings in a way that offers a reparative and healing experience, with the intention of preserving the wellbeing of clients when therapy processes are challenged or are drawing to a close (Pearlman & Courtois, 2005).

Therapists' own mental health challenges may influence their capacity to work effectively with clients experiencing complex trauma. Exposure to traumatic narratives places therapists at risk of vicarious traumatisation (McCann & Pearlman, 1990) and compassion fatigue, which can manifest in difficulties, such as emotional numbing, intrusive imagery, and dysregulation (Figley, 1995), bearing some similarities to the challenges experienced by individuals with complex trauma. These dynamics may complicate the therapeutic relationship, potentially impacting boundaries, attunement, and clinical decision-making (Pearlman & Saakvitne, 1995). Additionally, therapists' unresolved personal trauma or ongoing psychological difficulties can further influence transference and countertransference processes, reinforcing relational patterns, such as avoidance or dependence, that manifest within complex trauma presentations (Wallin, 2007). These considerations highlight the value of self-reflection, supervision, and organisational support as essential to safeguard the wellbeing of therapists and clients, and the integrity of therapeutic processes.

The considerations above highlight the importance of wider systemic factors for supporting individuals who experience complex trauma and the professionals who provide care. As discussed within the thesis introduction, there have been directives to instil Trauma-informed care models in mental health services for several years (Fallot & Harris, 2009). The relational values underpinning the framework align well with the outcomes of the systematic review and empirical paper, suggesting that relational practice not only takes place within smaller networks and dyads, but also on an organisational and cultural level. Developing our understanding of people's lived experiences in the broader context of their lives reduces the likelihood that individuals seeking help have their difficulties treated in isolation and enhances relational practices through improving understanding and empathy, which is fundamental to healing and growth (Boyle & Johnstone, 2014; Sweeney et al., 2016).

Research implications

Future qualitative research focusing on male participants could provide a more nuanced understanding of the specific ways in which complex trauma impacts personal relationships and may help identify particular barriers within clinical and research contexts. Similarly, studies examining the relational experiences of individuals from LGBTQ+ communities would be valuable in exploring how diverse social identities influence complex trauma and shape relational experiences. Further qualitative research into supervision processes for clinicians working with complex trauma populations could offer rich and meaningful insights into the effects of this work on therapists' wellbeing and enhance understanding of how supervision supports therapeutic practice. Additionally, research exploring the limitations and challenges of relational approaches within mental health services may illuminate the experiences of individuals with complex trauma in navigating organisational contexts.

Conclusion

Both studies highlight the profound impact of complex trauma on relational functioning and the fundamental role of corrective relational experiences in personal healing and growth. The systematic review identified core qualities of effective therapeutic relationships, including trust, safety, understanding, validation, therapist courage, clear boundaries, and collaboration, which led to the development of reparative attachment experiences. The empirical study demonstrated that complex trauma led to difficulties in personal relationships across the lifespan, including cycles of dependency and avoidance, boundary challenges, repeated dynamics, emotion regulation difficulties, and communication struggles, associated with the experience of early attachment trauma. Importantly, both studies highlight that adaptive relational experiences, whether in therapeutic or personal relationships, build safety, strengthen identity, support personal agency, and promote learning and growth. Together, the studies emphasise that relational safety, trust, and corrective

attachment experiences are fundamental qualities for healing in the context of complex trauma.

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Appendix A: Journal of Family Violence Author Guidelines

Instructions for Authors

General

The *Journal of Family Violence* (JOFV) is a peer-reviewed publication committed to the dissemination of rigorous research on preventing, ending, and ameliorating all forms of family violence. JOFV welcomes scholarly articles related to the broad categories of child abuse and maltreatment, child to parent abuse, sibling abuse, dating violence, domestic and intimate partner violence, and elder abuse. Within these categories, JOFV emphasizes research on physical, psychological, and sexual violence as well as homicides that occur in families. Studies on families in all their various forms and diversities are welcome.

All submitted manuscripts submitted to JOFV should reflect research and scholarship that has been conducted in an ethical manner. Please see "Springer's Guide: Publishing Ethics for Journals" for detailed guidance: http://www.springer.com/gp/partners/society-zone-issues/springer-s-guide-publishing-ethics-for-journals/15064.

Manuscripts, in American English, should be submitted to the Editor's Office via the journal's web-based online manuscript submission and peer-review system: https://www.editorialmanager.com/jofv/

When submitting a manuscript, authors are encouraged to include a cover letter including the following information as relevant. Note the type of manuscript being submitted, i.e., a Full-length Article, a Brief Report, a Systematic Review and/or Meta-Analysis, a Letter to the Editor, or a Special Article. Note if the findings presented in the study have been presented elsewhere previously, e.g., at a conference, in a dissertation, in a pre-print. Note if the study presented in the manuscript comes from a parent study, as well as how the present study is distinct from other research previously published from the parent study. Note when manuscript is being submitted in response to an invitation for a special issue. Authors are also encouraged to note any other information concerning the manuscript and study that may be important for editorial and peer review.

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Editorial procedure

Double-blind peer review

This journal follows a double-blind reviewing procedure. This means that the author will remain anonymous to the reviewers throughout peer review. It is the responsibility of the author to anonymize the manuscript and any associated materials.

- Author names, affiliations and any other potentially identifying information should be removed from the manuscript text and any accompanying files (such as figures of supplementary material);

- A separate Title Page should be submitted, containing title, author names, affiliations, and the contact information of the corresponding author. Any acknowledgements, disclosures, or funding information should also be included on this page;
- Authors should avoid citing their own work in a way that could reveal their identity.

This journal also publishes special/guest-edited issues. The peer review process for these articles is the same as the peer review process of the journal in general.

Additionally, if a guest editor authors an article in their issue/collection, they will not handle the peer review process.

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Article Types

JOFV publishes full-length articles that describe studies using rigorous quantitative, qualitative, and/or mixed methods involving the collection and analysis of primary data and/or the analysis of secondary data. Additionally, rigorous systematic reviews, meta-analyses, and theoretical analyses are welcome, as well as letters to the editor and brief reports. To help advance scientific understandings of family violence, JOFV is especially interested in research using transdisciplinary perspectives and innovative research methods. Because family violence is a global problem requiring solutions from diverse disciplinary perspectives, JOFV strongly encourages submissions from scholars worldwide from all disciplines and backgrounds.

Full-length Articles: Full-length articles reporting on the collection and analysis of primary data and/or the analysis of secondary data should not exceed 35 double-spaced pages, inclusive of title page, abstract, text, references, tables, figures, and footnotes.

Brief Reports: Authors may wish to share limited, though nonetheless important, findings and lessons-learned from the field, from practice, and from research, even when such results do not warrant a full-length article. Accordingly, JOFV welcomes the presentation of such results in the form of brief reports. Brief reports should not exceed 20 double-spaced pages, inclusive of title page, abstract, text, references, tables, figures, and footnotes. At submission, authors should indicate that their manuscript is a brief report in their cover letter to the editor. Also, authors are encouraged to indicate that their manuscript is a brief report in key places in the manuscript, such as the title, abstract, introduction, and discussion.

Systematic Reviews, Meta-Analyses, and Scoping Reviews: JOFV welcomes rigorous systematic reviews, meta-analyses, and scoping reviews. These manuscripts should not exceed 40 double-spaced pages, inclusive of title page, abstract, text, references, tables, figures, and footnotes. All reviewed articles should be cited in the reference list with an asterisk preceding the first author's name (e.g., *Watson, K. K, & Ellison, E.,…). PRISMA should be used for reporting in systematic reviews and meta-analyses. PRISMA-ScR should be used for reporting in scoping reviews.

Letters to the Editor: Letters to the Editor are brief articles that respond to content published in JOFV. These pieces should promote beneficial and thoughtful discussions of

JOFV content, as well as of important issues in the family violence field broadly. Such letters are typically brief (i.e., no more than 10 pages in length and often less). When commenting on a published JOFV article, such letters should be submitted in a timely manner (i.e., soon after the article appears in online first or in print). See Johnson and Green's (2006) article on writing Letters to the Editor for guidance: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2647072/

Research Rigor

Authors are encouraged to submit full-length articles, briefs, systematic reviews, and meta-analyses that describe rigorous research and provide adequate information about study methods. Definitions of and standards for rigor vary across study approaches, epistemologies, designs, and methods. Rather than promoting one set of methods or standards, JOFV will seek to publish scholarship that carefully and thoughtfully attends to consideration of rigor using the framework and methods that are most relevant for the study and research questions at hand. For additional guidance concerning the conduct and reporting of rigorous studies, please see the information in the "Standards of Reporting" section below.

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Contact Information

Inquiries regarding journal policy, manuscript preparation, and other such general topics can be sent to the Editor-In-Chief, Dr. Lynette M. Renner:

Lynette M. Renner, PhD, MSW

Professor

University of Minnesota-Twin Cities

School of Social Work

1404 Gortner Avenue

St. Paul, MN 55108

renn0042@umn.edu

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Manuscript Submission

Manuscript Submission

Submission of a manuscript implies: that the work described has not been published before; that it is not under consideration for publication anywhere else; that its publication has been approved by all co-authors, if any, as well as by the responsible authorities – tacitly or

explicitly – at the institute where the work has been carried out. The publisher will not be held legally responsible should there be any claims for compensation.

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Online Submission

Please follow the hyperlink "Submit manuscript" and upload all of your manuscript files following the instructions given on the screen.

Source Files

Please ensure you provide all relevant editable source files at every submission and revision. Failing to submit a complete set of editable source files will result in your article not being considered for review. For your manuscript text please always submit in common word processing formats such as .docx or LaTeX.

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Title page

Please make sure your title page contains the following information.

Title

The title should be concise and informative.

Author information

- The name(s) of the author(s)
- The affiliation(s) of the author(s), i.e. institution, (department), city, (state), country
- A clear indication and an active e-mail address of the corresponding author
- If available, the 16-digit ORCID of the author(s)

If address information is provided with the affiliation(s) it will also be published.

For authors that are (temporarily) unaffiliated we will only capture their city and country of residence, not their e-mail address unless specifically requested.

Large Language Models (LLMs), such as ChatGPT, do not currently satisfy our authorship criteria. Notably an attribution of authorship carries with it accountability for the work, which cannot be effectively applied to LLMs. Use of an LLM should be properly documented in the Methods section (and if a Methods section is not available, in a suitable alternative part) of

the manuscript. The use of an LLM (or other AI-tool) for "AI assisted copy editing" purposes does not need to be declared. In this context, we define the term "AI assisted copy editing" as AI-assisted improvements to human-generated texts for readability and style, and to ensure that the texts are free of errors in grammar, spelling, punctuation and tone. These AI-assisted improvements may include wording and formatting changes to the texts, but do not include generative editorial work and autonomous content creation. In all cases, there must be human accountability for the final version of the text and agreement from the authors that the edits reflect their original work.

Abstract

Please provide a structured abstract of 150 to 250 words which should be divided into the following sections:

- Purpose (stating the main purposes and research question)
- Methods
- Results
- Conclusions

Please note: For some articles (particularly, systematic reviews and original research articles), 250 words may not be sufficient to provide all necessary information in the abstract. Therefore, the abstract length can be increased from the 250-word limit (to up to 450 words) if the topic dictates, and to allow full compliance with the relevant reporting guidelines.

For life science journals only (when applicable)

- Trial registration number and date of registration for prospectively registered trials
- Trial registration number and date of registration, followed by “retrospectively registered”, for retrospectively registered trials

Keywords

Please provide 4 to 6 keywords which can be used for indexing purposes.

Acknowledgements

An Acknowledgment section may be included to acknowledge, for example, people who have assisted with aspects of the work (but who do not qualify as authors), disclaimers, collaborations, etc.

Statements and Declarations

The following statements should be included under the heading "Statements and Declarations" for inclusion in the published paper. Please note that submissions that do not include relevant declarations will be returned as incomplete.

- **Competing Interests:** Authors are required to disclose financial or non-financial interests that are directly or indirectly related to the work submitted for publication.

Please refer to “Competing Interests and Funding” below for more information on how to complete this section.

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Text

Text Formatting

Manuscripts should be submitted in Word.

- Use a normal, plain font (e.g., 10-point Times Roman) for text.
- Use italics for emphasis.
- Use the automatic page numbering function to number the pages.
- Do not use field functions.
- Use tab stops or other commands for indents, not the space bar.
- Use the table function, not spreadsheets, to make tables.
- Use the equation editor or MathType for equations.
- Save your file in docx format (Word 2007 or higher) or doc format (older Word versions).

Headings

Please use no more than three levels of displayed headings.

Abbreviations

Abbreviations should be defined at first mention and used consistently thereafter.

Footnotes

Footnotes can be used to give additional information, which may include the citation of a reference included in the reference list. They should not consist solely of a reference citation, and they should never include the bibliographic details of a reference. They should also not contain any figures or tables.

Footnotes to the text are numbered consecutively; those to tables should be indicated by superscript lower-case letters (or asterisks for significance values and other statistical data). Footnotes to the title or the authors of the article are not given reference symbols.

Always use footnotes instead of endnotes.

Acknowledgments

Acknowledgments of people, grants, funds, etc. should be placed in a separate section on the title page. The names of funding organizations should be written in full.

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Scientific style

- Please always use internationally accepted signs and symbols for units (SI units).
- Generic names of drugs and pesticides are preferred; if trade names are used, the generic name should be given at first mention.
- Please use the standard mathematical notation for formulae, symbols, etc.: Italic for single letters that denote mathematical constants, variables, and unknown quantities; Roman/upright for numerals, operators, and punctuation, and commonly defined functions or abbreviations, e.g., cos, det, e or exp, lim, log, max, min, sin, tan, d (for derivative); Bold for vectors, tensors, and matrices.

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References

Citation

Cite references in the text by name and year in parentheses. Some examples:

- Negotiation research spans many disciplines (Thompson, 1990).
- This result was later contradicted by Becker and Seligman (1996).
- This effect has been widely studied (Abbott, 1991; Barakat et al., 1995; Kelso & Smith, 1998; Medvec et al., 1999).

Authors are encouraged to follow official APA version 7 guidelines on the number of authors included in reference list entries (i.e., include all authors up to 20; for larger groups, give the first 19 names followed by an ellipsis and the final author's name). However, if authors shorten the author group by using et al., this will be retained.

Reference list

The list of references should only include works that are cited in the text and that have been published or accepted for publication. Personal communications and unpublished works should only be mentioned in the text.

Reference list entries should be alphabetized by the last names of the first author of each work.

Journal names and book titles should be *italicized*.

If available, please always include DOIs as full DOI links in your reference list (e.g. "https://doi.org/abc").

- Journal article Grady, J. S., Her, M., Moreno, G., Perez, C., & Yelinek, J. (2019). Emotions in storybooks: A comparison of storybooks that represent ethnic and racial groups in the United States. *Psychology of Popular Media Culture, 8*(3), 207–217. https://doi.org/10.1037/ppm0000185
- Article by DOI Hong, I., Knox, S., Pryor, L., Mroz, T. M., Graham, J., Shields, M. F., & Reistetter, T. A. (2020). Is referral to home health rehabilitation following inpatient rehabilitation facility associated with 90-day hospital readmission for adult patients

with stroke? *American Journal of Physical Medicine & Rehabilitation*. Advance online publication. https://doi.org/10.1097/PHM.0000000000001435

- Book Sapolsky, R. M. (2017). *Behave: The biology of humans at our best and worst*. Penguin Books.
- Book chapter Dillard, J. P. (2020). Currents in the study of persuasion. In M. B. Oliver, A. A. Raney, & J. Bryant (Eds.), *Media effects: Advances in theory and research* (4th ed., pp. 115–129). Routledge.
- Online document Fagan, J. (2019, March 25). *Nursing clinical brain*. OER Commons. Retrieved January 7, 2020, from https://www.oercommons.org/authoring/53029-nursing-clinical-brain/view

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Tables

- All tables are to be numbered using Arabic numerals.
- Tables should always be cited in text in consecutive numerical order.
- For each table, please supply a table caption (title) explaining the components of the table.
- Identify any previously published material by giving the original source in the form of a reference at the end of the table caption.
- Footnotes to tables should be indicated by superscript lower-case letters (or asterisks for significance values and other statistical data) and included beneath the table body.

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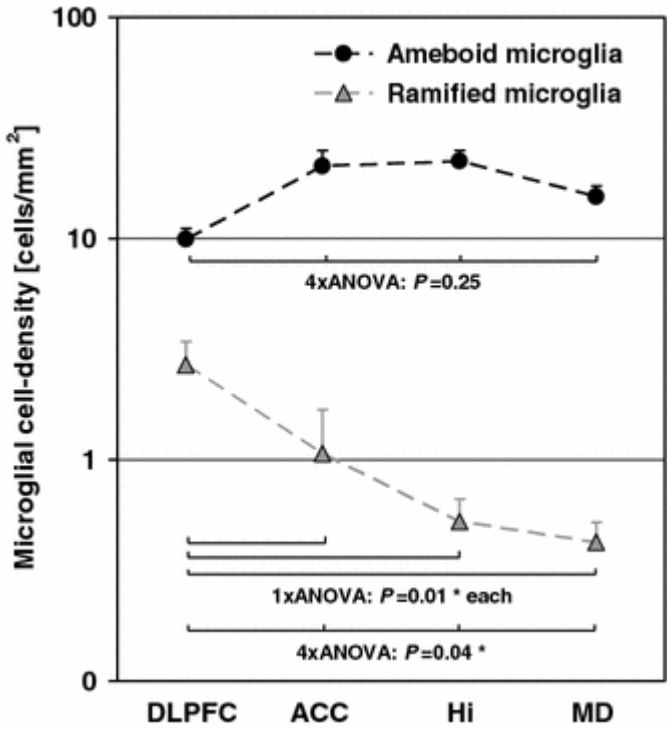
Artwork and Illustrations Guidelines

Electronic Figure Submission

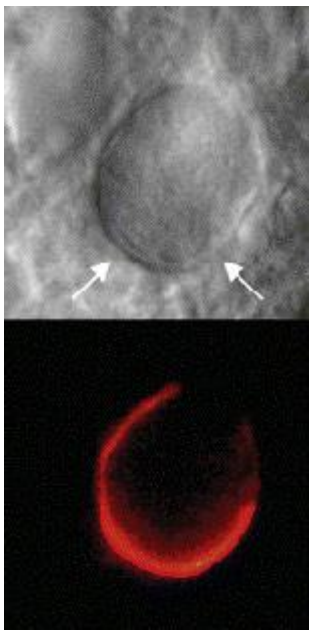
- Supply all figures electronically.
- Indicate what graphics program was used to create the artwork.
- For vector graphics, the preferred format is EPS; for halftones, please use TIFF format. MSOffice files are also acceptable.
- Vector graphics containing fonts must have the fonts embedded in the files.
- Name your figure files with "Fig" and the figure number, e.g., Fig1.eps.

Line Art



- Definition: Black and white graphic with no shading.
- Do not use faint lines and/or lettering and check that all lines and lettering within the figures are legible at final size.
- All lines should be at least 0.1 mm (0.3 pt) wide.
- Scanned line drawings and line drawings in bitmap format should have a minimum resolution of 1200 dpi.
- Vector graphics containing fonts must have the fonts embedded in the files.

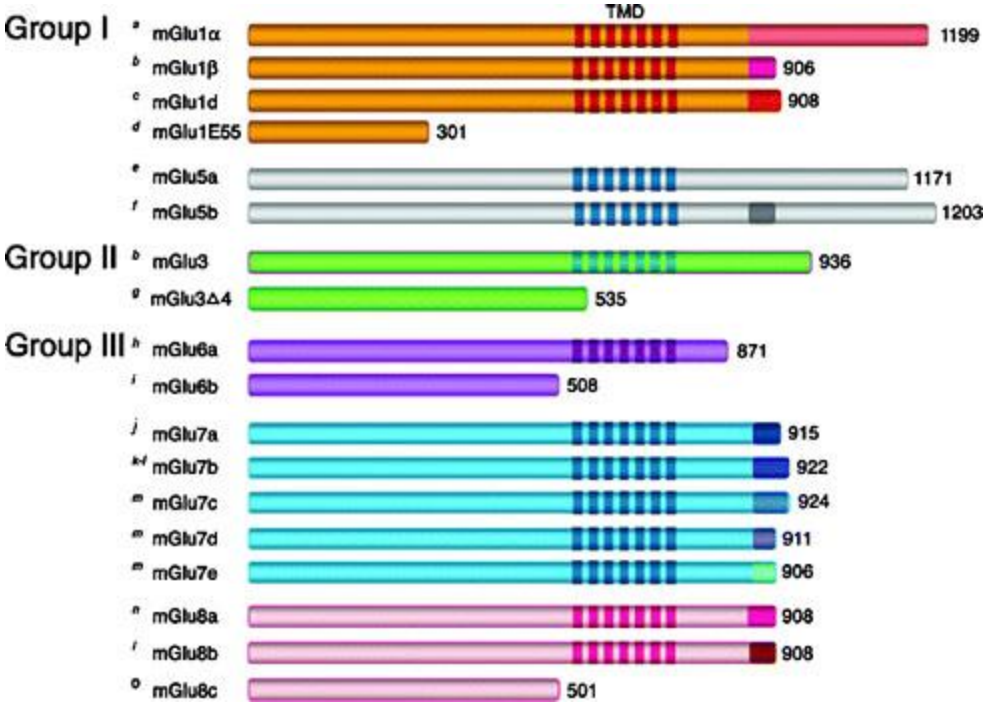
Halftone Art



- Definition: Photographs, drawings, or paintings with fine shading, etc.

- If any magnification is used in the photographs, indicate this by using scale bars within the figures themselves.
- Halftones should have a minimum resolution of 300 dpi.

Combination Art



- Definition: a combination of halftone and line art, e.g., halftones containing line drawing, extensive lettering, color diagrams, etc.
- Combination artwork should have a minimum resolution of 600 dpi.

Color Art

- Color art is free of charge for online publication.
- If black and white will be shown in the print version, make sure that the main information will still be visible. Many colors are not distinguishable from one another when converted to black and white. A simple way to check this is to make a xerographic copy to see if the necessary distinctions between the different colors are still apparent.
- If the figures will be printed in black and white, do not refer to color in the captions.
- Color illustrations should be submitted as RGB (8 bits per channel).

Figure Lettering

- To add lettering, it is best to use Helvetica or Arial (sans serif fonts).
- Keep lettering consistently sized throughout your final-sized artwork, usually about 2–3 mm (8–12 pt).
- Variance of type size within an illustration should be minimal, e.g., do not use 8-pt type on an axis and 20-pt type for the axis label.
- Avoid effects such as shading, outline letters, etc.
- Do not include titles or captions within your illustrations.

Figure Numbering

- All figures are to be numbered using Arabic numerals.
- Figures should always be cited in text in consecutive numerical order.
- Figure parts should be denoted by lowercase letters (a, b, c, etc.).
- If an appendix appears in your article and it contains one or more figures, continue the consecutive numbering of the main text. Do not number the appendix figures,"A1, A2, A3, etc." Figures in online appendices [Supplementary Information (SI)] should, however, be numbered separately.

Figure Captions

- Each figure should have a concise caption describing accurately what the figure depicts. Include the captions in the text file of the manuscript, not in the figure file.
- Figure captions begin with the term Fig. in bold type, followed by the figure number, also in bold type.
- No punctuation is to be included after the number, nor is any punctuation to be placed at the end of the caption.
- Identify all elements found in the figure in the figure caption; and use boxes, circles, etc., as coordinate points in graphs.
- Identify previously published material by giving the original source in the form of a reference citation at the end of the figure caption.

Figure Placement and Size

- Figures should be submitted within the body of the text. Only if the file size of the manuscript causes problems in uploading it, the large figures should be submitted separately from the text.
- When preparing your figures, size figures to fit in the column width.
- For large-sized journals the figures should be 84 mm (for double-column text areas), or 174 mm (for single-column text areas) wide and not higher than 234 mm.
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Accessibility

In order to give people of all abilities and disabilities access to the content of your figures, please make sure that

- All figures have descriptive captions (blind users could then use a text-to-speech software or a text-to-Braille hardware)

- Patterns are used instead of or in addition to colors for conveying information (colorblind users would then be able to distinguish the visual elements)
- Any figure lettering has a contrast ratio of at least 4.5:1

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Springer accepts electronic multimedia files (animations, movies, audio, etc.) and other supplementary files to be published online along with an article or a book chapter. This feature can add dimension to the author's article, as certain information cannot be printed or is more convenient in electronic form.

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- Supply all supplementary material in standard file formats.
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- To accommodate user downloads, please keep in mind that larger-sized files may require very long download times and that some users may experience other problems during downloading.

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- Aspect ratio: 16:9 or 4:3
- Maximum file size: 2 GB
- Minimum video duration: 1 sec
- Supported file formats: avi, wmv, mp4, mov, m2p, mp2, mpg, mpeg, flv, mxf, mts, m4v, 3gp

Text and Presentations

- Submit your material in PDF format; .doc or .ppt files are not suitable for long-term viability.
- A collection of figures may also be combined in a PDF file.

Spreadsheets

- Spreadsheets should be submitted as .csv or .xlsx files (MS Excel).

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- Specialized format such as .pdb (chemical), .wrl (VRML), .nb (Mathematica notebook), and .tex can also be supplied.

Collecting Multiple Files

- It is possible to collect multiple files in a .zip or .gz file.

Numbering

- If supplying any supplementary material, the text must make specific mention of the material as a citation, similar to that of figures and tables.
- Refer to the supplementary files as “Online Resource”, e.g., "... as shown in the animation (Online Resource 3)", “... additional data are given in Online Resource 4”.
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Captions

- For each supplementary material, please supply a concise caption describing the content of the file.

Processing of supplementary files

- Supplementary Information (SI) will be published as received from the author without any conversion, editing, or reformatting.

Accessibility

In order to give people of all abilities and disabilities access to the content of your supplementary files, please make sure that

- The manuscript contains a descriptive caption for each supplementary material
- Video files do not contain anything that flashes more than three times per second (so that users prone to seizures caused by such effects are not put at risk)

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This journal is committed to upholding the integrity of the scientific record. As a member of the Committee on Publication Ethics (COPE) the journal will follow the COPE guidelines on how to deal with potential acts of misconduct.

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- A single study should not be split up into several parts to increase the quantity of submissions and submitted to various journals or to one journal over time (i.e. ‘salami-slicing/publishing’).
- Concurrent or secondary publication is sometimes justifiable, provided certain conditions are met. Examples include: translations or a manuscript that is intended for a different group of readers.
- Results should be presented clearly, honestly, and without fabrication, falsification or inappropriate data manipulation (including image based manipulation). Authors should adhere to discipline-specific rules for acquiring, selecting and processing data.
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- Research articles and non-research articles (e.g. Opinion, Review, and Commentary articles) must cite appropriate and relevant literature in support of the claims made. Excessive and inappropriate self-citation or coordinated efforts among several authors to collectively self-cite is strongly discouraged.
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- Research that may be misapplied to pose a threat to public health or national security should be clearly identified in the manuscript (e.g. dual use of research). Examples include creation of harmful consequences of biological agents or toxins, disruption of immunity of vaccines, unusual hazards in the use of chemicals, weaponization of research/technology (amongst others).
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Upon request authors should be prepared to send relevant documentation or data in order to verify the validity of the results presented. This could be in the form of raw data, samples, records, etc. Sensitive information in the form of confidential or proprietary data is excluded.

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- If the article has already been published online, depending on the nature and severity of the infraction:

  - an erratum/correction may be placed with the article

  - an expression of concern may be placed with the article

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The reason will be given in the published erratum/correction, expression of concern or retraction note. Please note that retraction means that the article is **maintained on the platform**, watermarked "retracted" and the explanation for the retraction is provided in a note linked to the watermarked article.

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- A notice of suspected transgression of ethical standards in the peer review system may be included as part of the author's and article's bibliographic record.

Fundamental errors

Authors have an obligation to correct mistakes once they discover a significant error or inaccuracy in their published article. The author(s) is/are requested to contact the journal and explain in what sense the error is impacting the article. A decision on how to correct the literature will depend on the nature of the error. This may be a correction or retraction. The retraction note should provide transparency which parts of the article are impacted by the error.

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Authors are welcome to suggest suitable reviewers and/or request the exclusion of certain individuals when they submit their manuscripts. When suggesting reviewers, authors should make sure they are totally independent and not connected to the work in any way. It is strongly recommended to suggest a mix of reviewers from different countries and different institutions. When suggesting reviewers, the Corresponding Author must provide an institutional email address for each suggested reviewer, or, if this is not possible to include other means of verifying the identity such as a link to a personal homepage, a link to the publication record or a researcher or author ID in the submission letter. Please note that the Journal may not use the suggestions, but suggestions are appreciated and may help facilitate the peer review process.

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Authorship principles

These guidelines describe authorship principles and good authorship practices to which prospective authors should adhere to.

Authorship clarified

The Journal and Publisher assume all authors agreed with the content and that all gave explicit consent to submit and that they obtained consent from the responsible authorities at the institute/organization where the work has been carried out, **before** the work is submitted.

The Publisher does not prescribe the kinds of contributions that warrant authorship. It is recommended that authors adhere to the guidelines for authorship that are applicable in their specific research field. In absence of specific guidelines it is recommended to adhere to the following guidelines*:

All authors whose names appear on the submission

1) made substantial contributions to the conception or design of the work; or the acquisition, analysis, or interpretation of data; or the creation of new software used in the work;

2) drafted the work or revised it critically for important intellectual content;

3) approved the version to be published; and

4) agree to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

* Based on/adapted from:

ICMJE, Defining the Role of Authors and Contributors,

Transparency in authors' contributions and responsibilities to promote integrity in scientific publication, McNutt at all, PNAS February 27, 2018

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A Graduate Student's Guide to Determining Authorship Credit and Authorship Order, APA Science Student Council 2006

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Under ‘summary of requirements’ (see below) funding information should be included in the ‘**Declarations**’ section.

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- Partial financial support was received from [...]
- The research leading to these results received funding from […] under Grant Agreement No[…].
- This study was funded by […]
- This work was supported by […] (Grant numbers […] and […]

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- The authors did not receive support from any organization for the submitted work.
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When reporting a study that involved human participants, their data or biological material, authors should include a statement that confirms that the study was approved (or granted exemption) by the appropriate institutional and/or national research ethics committee (including the name of the ethics committee) and certify that the study was performed in accordance with the ethical standards as laid down in the 1964 Declaration of Helsinki and its later amendments or comparable ethical standards. If doubt exists whether the research was conducted in accordance with the 1964 Helsinki Declaration or comparable standards, the authors must explain the reasons for their approach, and demonstrate that an independent ethics committee or institutional review board explicitly approved the doubtful aspects of the study. If a study was granted exemption from requiring ethics approval, this should also be detailed in the manuscript (including the reasons for the exemption).

Retrospective ethics approval

If a study has not been granted ethics committee approval prior to commencing, retrospective ethics approval usually cannot be obtained and it may not be possible to consider the

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Although retrospective studies are conducted on already available data or biological material (for which formal consent may not be needed or is difficult to obtain) ethics approval may be required dependent on the law and the national ethical guidelines of a country. Authors should check with their institution to make sure they are complying with the specific requirements of their country.

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If human cells are used, authors must declare in the manuscript: what cell lines were used by describing the source of the cell line, including when and from where it was obtained, whether the cell line has recently been authenticated and by what method. If cells were bought from a life science company the following need to be given in the manuscript: name of company (that provided the cells), cell type, number of cell line, and batch of cells.

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Please see the various examples of wording below and revise/customize the sample statements according to your own needs.

Examples of statements to be used when ethics approval has been obtained:

• All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki Declaration and its later amendments or comparable ethical standards. The study was approved by the Bioethics Committee of the Medical University of A (No. ...).

• This study was performed in line with the principles of the Declaration of Helsinki. Approval was granted by the Ethics Committee of University B (Date.../No. ...).

• Approval was obtained from the ethics committee of University C. The procedures used in this study adhere to the tenets of the Declaration of Helsinki.

• The questionnaire and methodology for this study was approved by the Human Research Ethics committee of the University of D (Ethics approval number: ...).

Examples of statements to be used for a retrospective study:

• Ethical approval was waived by the local Ethics Committee of University A in view of the retrospective nature of the study and all the procedures being performed were part of the routine care.

• This research study was conducted retrospectively from data obtained for clinical purposes. We consulted extensively with the IRB of XYZ who determined that our study did not need ethical approval. An IRB official waiver of ethical approval was granted from the IRB of XYZ.

• This retrospective chart review study involving human participants was in accordance with the ethical standards of the institutional and national research committee and with the 1964 Helsinki Declaration and its later amendments or comparable ethical standards. The Human Investigation Committee (IRB) of University B approved this study.

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• This is an observational study. The XYZ Research Ethics Committee has confirmed that no ethical approval is required.

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Informed consent

All individuals have individual rights that are not to be infringed. Individual participants in studies have, for example, the right to decide what happens to the (identifiable) personal data gathered, to what they have said during a study or an interview, as well as to any photograph that was taken. This is especially true concerning images of vulnerable people (e.g. minors, patients, refugees, etc) or the use of images in sensitive contexts. In many instances authors will need to secure written consent before including images.

Identifying details (names, dates of birth, identity numbers, biometrical characteristics (such as facial features, fingerprint, writing style, voice pattern, DNA or other distinguishing characteristic) and other information) of the participants that were studied should not be published in written descriptions, photographs, and genetic profiles unless the information is essential for scholarly purposes and the participant (or parent/guardian if the participant is a minor or incapable or legal representative) gave written informed consent for publication. Complete anonymity is difficult to achieve in some cases. Detailed descriptions of individual participants, whether of their whole bodies or of body sections, may lead to disclosure of their identity. Under certain circumstances consent is not required as long as information is anonymized and the submission does not include images that may identify the person.

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Consent and already available data and/or biologic material

Regardless of whether material is collected from living or dead patients, they (family or guardian if the deceased has not made a pre-mortem decision) must have given prior written consent. The aspect of confidentiality as well as any wishes from the deceased should be respected.

Data protection, confidentiality and privacy

When biological material is donated for or data is generated as part of a research project authors should ensure, as part of the informed consent procedure, that the participants are made aware what kind of (personal) data will be processed, how it will be used and for what purpose. In case of data acquired via a biobank/biorepository, it is possible they apply a broad consent which allows research participants to consent to a broad range of uses of their data and samples which is regarded by research ethics committees as specific enough to be considered "informed". However, authors should always check the specific biobank/biorepository policies or any other type of data provider policies (in case of non-bio research) to be sure that this is the case.

Consent to Participate

For all research involving human subjects, freely-given, informed consent to participate in the study must be obtained from participants (or their parent or legal guardian in the case of children under 16) and a statement to this effect should appear in the manuscript. In the case of articles describing human transplantation studies, authors must include a statement declaring that no organs/tissues were obtained from prisoners and must also name the institution(s)/clinic(s)/department(s) via which organs/tissues were obtained. For manuscripts reporting studies involving vulnerable groups where there is the potential for coercion or where consent may not have been fully informed, extra care will be taken by the editor and may be referred to the Springer Nature Research Integrity Group.

Consent to Publish

Individuals may consent to participate in a study, but object to having their data published in a journal article. Authors should make sure to also seek consent from individuals to publish their data prior to submitting their paper to a journal. This is in particular applicable to case studies. A consent to publish form can be found

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Summary of requirements

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Please see the various examples of wording below and revise/customize the sample statements according to your own needs.

Sample statements for **"Consent to participate"**:

Informed consent was obtained from all individual participants included in the study.

Informed consent was obtained from legal guardians.

Written informed consent was obtained from the parents.

Verbal informed consent was obtained prior to the interview.

Sample statements for **"Consent to publish"**:

The authors affirm that human research participants provided informed consent for publication of the images in Figure(s) 1a, 1b and 1c.

The participant has consented to the submission of the case report to the journal.

Patients signed informed consent regarding publishing their data and photographs.

Sample statements if identifying information about participants is available in the article:

Additional informed consent was obtained from all individual participants for whom identifying information is included in this article.

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Appendix B: HRA Approval Letter

Miss Caroline Mangham
Trainee Clinical Psychologist
Email: HCRW.approvals@wales.nhs.uk

Cambridgeshire and Peterborough NHS Foundation Trust
Elizabeth House, Fulbourn Hospital
Cambridge Road
Cambridge
CB21 5EF

25 March 2024

Dear Miss Mangham

HRA and Health and Care

Study title:	**Exploring the impact of complex trauma on personal relationships: An Interpretive Phenomenological Analysis**
IRAS project ID:	**335519**
REC reference:	**24/NI/0040**
Sponsor	**University of East Anglia - Research and Innovation Services**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The standard conditions document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **335519**. Please quote this on all correspondence.

Yours sincerely,
Sue Byng

Approvals Specialist

Email: HCRW.approvals@wales.nhs.uk

Copy to: *Ms Tracy Moulton* **List of Documents**

The final document set assessed and approved by HRA and HCRW Approval is listed below.

Document	*Version*	*Date*
Copies of materials calling attention of potential participants to the research [Recruitment Poster v2]	2	05 March 2024
Copies of materials calling attention of potential participants to the research [Participant Information Sheet v5]	5	04 March 2024
Covering letter on headed paper [Research Proposal Cover Letter v2]	2	05 February 2024
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [UEA PI Letter 23-24]	1	01 August 2023
Interview schedules or topic guides for participants [Topic Guide v3]	3	04 March 2024
IRAS Application Form [IRAS_Form_29022024]		29 February 2024
Letter from sponsor [Letter from Sponsor (University of East Anglia)]	1	29 February 2024
Non-validated questionnaire [Debrief Form v2]	2	04 March 2024
Organisation Information Document [Organisation Information Document]	3	04 March 2024
Participant consent form [Informed Consent Form v5]	5	21 March 2024
Participant consent form [Consent to Contact Form v2]	2	04 March 2024
Participant information sheet (PIS) [Participant Information Sheet v6]	6	21 March 2024
Referee's report or other scientific critique report [Research Proposal UEA Markers Feedback]	1	11 August 2023
Research protocol or project proposal [Research Proposal v3]	3	04 March 2024
Schedule of Events or SoECAT [Schedule of Events]	1	11 February 2024
Summary CV for Chief Investigator (CI) [CM (Chief Investigator) CV]	1	12 December 2023
Summary CV for student [CM (Chief Investigator) CV]	1	12 December 2023
Summary CV for supervisor (student research) [LH (Primary Supervisor) CV]	1	11 December 2023
Summary CV for supervisor (student research) [PF (Secondary Supervisor) CV]	1	11 December 2023
Summary of any applicable exclusions to sponsor insurance (nonNHS sponsors only) [UEA EL & PL Letter 23-24]	1	01 August 2023

IRAS project ID	335519

Information to support study set up

The below provides all parties with information to support the arranging and confirming of capacity and capability with participating NHS organisations in England and Wales. This is intended to be an accurate reflection of the study at the time of issue of this letter.

Types of participating NHS organisation	Expectations related to confirmation of capacity and capability	Agreement to be used	Funding arrangements	Oversight expectations	HR Good Practice Resource Pack expectations

Research activities and procedures as per the protocol and other study documents will take place at participating NHS organisations.	Research activities should not commence at participating NHS organisations in England or Wales prior to their formal confirmation of capacity and capability to deliver the study in accordance with the contracting expectations detailed. Due to the nature of the activities involved, organisations will be expected to provide that confirmation to the sponsor • Within 35 days of receipt of the local information pack • After HRA/HCRW	An Organisation Information Document has been submitted and the sponsor is not requesting and does not expect any other agreement to be used with participating NHS organisations of this type.	No external funding is being sought.	A Local Collaborator should be appointed at participating NHS organisations.	Where an external individual who does not already hold an NHS employment contract will be conducting any of the research activities that will be undertaken at this site type then they would be expected to hold an Honorary Research Contract. External staff holding preexisting NHS employment contracts should obtain a Letter of Access. These should confirm Occupational Health Clearance. These should confirm [enhanced/standard] DBS checks [and appropriate barred list checks].

	Approval has been issued. If the organisation is not able to formally confirm capacity and capability within this timeframe, they must inform the sponsor of this and provide a justification. If the sponsor is not satisfied with the justification, then the sponsor may escalate to the National Coordinating Function where the participating NHS organisation is located.				

Other information to aid study set-up and delivery

This details any other information that may be helpful to sponsors and participating NHS organisations in England and Wales in study set-up.
The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio.

Appendix C: REC Approval Letter

HSC Business Services Organisation

INVESTORS IN PEOPLE® We invest in people Silver

Health and Social Care Research Ethics Committee A (HSC REC A) Email: reca@hscni.net

21 March 2024

Miss Caroline Mangham
Trainee Clinical Psychologist
Cambridgeshire and Peterborough NHS Foundation Trust
Elizabeth House, Fulbourn Hospital
Cambridge Road
Cambridge
CB21 5EF

Dear Miss Mangham

Study title:	**Exploring the impact of complex trauma on personal relationships: An Interpretive Phenomenological Analysis**
REC reference:	**24/NI/0040**
IRAS project ID:	**335519**

Thank you for your letter of 21March 2024, responding to the Research Ethics Committee's (REC) request for further information on the above research and submitting revised documentation.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Good practice principles and responsibilities

The UK Policy Framework for Health and Social Care Research sets out principles of good practice in the management and conduct of health and social care research. It also outlines the responsibilities of individuals and organisations, including those related to the four elements of research transparency:

1. registering research studies
2. reporting results

3. informing participants
4. sharing study data and tissue

Conditions of the favourable opinion

Confirmation of Capacity and Capability (in England, Northern Ireland and Wales) or NHS management permission (in Scotland) should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it

has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for HRA and HCRW Approval (England and Wales)/ NHS permission for research is available in the Integrated Research Application System.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations

Registration of Clinical Trials

All research should be registered in a publicly accessible database and we expect all researchers, research sponsors and others to meet this fundamental best practice standard.

It is a condition of the REC favourable opinion that **all clinical trials are registered** on a public registry before the first participant is recruited and no later than six weeks after. For this purpose, 'clinical trials' are defined as:

- clinical trial of an investigational medicinal product
- clinical investigation or other study of a medical device
- combined trial of an investigational medicinal product and an investigational medical device
- other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice.

A 'public registry' means any registry on the WHO list of primary registries or the ICMJE list of registries provided the registry facilitates public access to information about the UK trial.

Failure to register a clinical trial is a breach of these approval conditions, unless a deferral has been agreed by the HRA (for more information on registration and requesting a deferral see: Research registration and research project identifiers).

Where a deferral is agreed we expect the sponsor to publish a minimal record on a publicly accessible registry. When the deferral period ends, the sponsor should publish the full record on the same registry, to fulfil the condition of the REC favourable opinion.

If you have not already included registration details in your IRAS application form you should notify the REC of the registration details as soon as possible.

Where the study is registered on ClinicalTrials.gov, please inform deferrals@hra.nhs.uk and the Research Ethics Committee (REC) which issued the final ethical opinion so that our records can be updated.

Publication of Your Research Summary

We will publish your research summary for the above study on the research summaries section of our website, together with your contact details, no earlier than three months from the date of this favourable opinion letter. Where a deferral is agreed, a minimum research summary will still be published in the research summaries database. At the end of the deferral period, we will publish the full research summary.

Should you wish to provide a substitute contact point, make a request to defer, or require further information, please visit: Research summaries - Health Research Authority (hra.nhs.uk)

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

After ethical review: Reporting requirements

The attached document “After ethical review – guidance for researchers” gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study, including early termination of the study
- Final report
- Reporting results

The latest guidance on these topics can be found at Managing your approval - Health Research Authority (hra.nhs.uk)

Ethical review of research sites

NHS/HSC sites

The favourable opinion applies to all NHS/HSC sites taking part in the study, subject to confirmation of Capacity and Capability (in England, Northern Ireland and Wales) or management permission (in Scotland) being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Copies of materials calling attention of potential participants to the research [Recruitment Poster v2]	2	05 March 2024
Copies of materials calling attention of potential participants to the research [Participant Information Sheet v5]	5	04 March 2024
Covering letter on headed paper [Research Proposal Cover Letter v2]	2	05 February 2024
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [UEA PI Letter 23-24]	1	01 August 2023
Interview schedules or topic guides for participants [Topic Guide v3]	3	04 March 2024
IRAS Application Form [IRAS_Form_29022024]		29 February 2024
Letter from sponsor [Letter from Sponsor (University of East Anglia)]	1	29 February 2024
Non-validated questionnaire [Debrief Form v2]	2	04 March 2024
Participant consent form [Consent to Contact Form v2]	2	04 March 2024
Participant consent form [Informed Consent Form v5]	5	21 March 2024
Participant information sheet (PIS) [Participant Information Sheet v6]	6	21 March 2024
Referee's report or other scientific critique report [Research Proposal UEA Markers Feedback]	1	11 August 2023
Research protocol or project proposal [Research Proposal v3]	3	04 March 2024
Summary CV for Chief Investigator (CI) [CM (Chief Investigator) CV]	1	12 December 2023
Summary CV for student [CM (Chief Investigator) CV]	1	12 December 2023
Summary CV for supervisor (student research) [LH (Primary Supervisor) CV]	1	11 December 2023
Summary CV for supervisor (student research) [PF (Secondary Supervisor) CV]	1	11 December 2023
Summary of any applicable exclusions to sponsor insurance (nonNHS sponsors only) [UEA EL & PL Letter 23-24]	1	01 August 2023

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: Quality assurance - Health Research Authority (hra.nhs.uk)

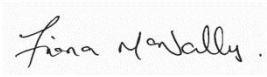
HRA Learning

We are pleased to welcome researchers and research staff to our HRA Learning Events and online learning opportunities– see details at: Learning - Health Research Authority (hra.nhs.uk)

IRAS project ID: 335519 Please quote this number on all correspondence

With the Committee's best wishes for the success of this project.

Yours
sincerely



pp Dr Mary Murphy
Chair of meeting

Email:RECA@hscni.net

Enclosures: List of names and professions of members who were present at the meeting and those who submitted written comments
"After ethical review – guidance for researchers"

Copy to: Ms Tracy Moulton

Lead Nation Northern Ireland: research.gateway@hscni.net

Appendix D: Recruitment Poster

Version 2: 05/03/2024

Doctorate in Clinical Psychology Recruitment

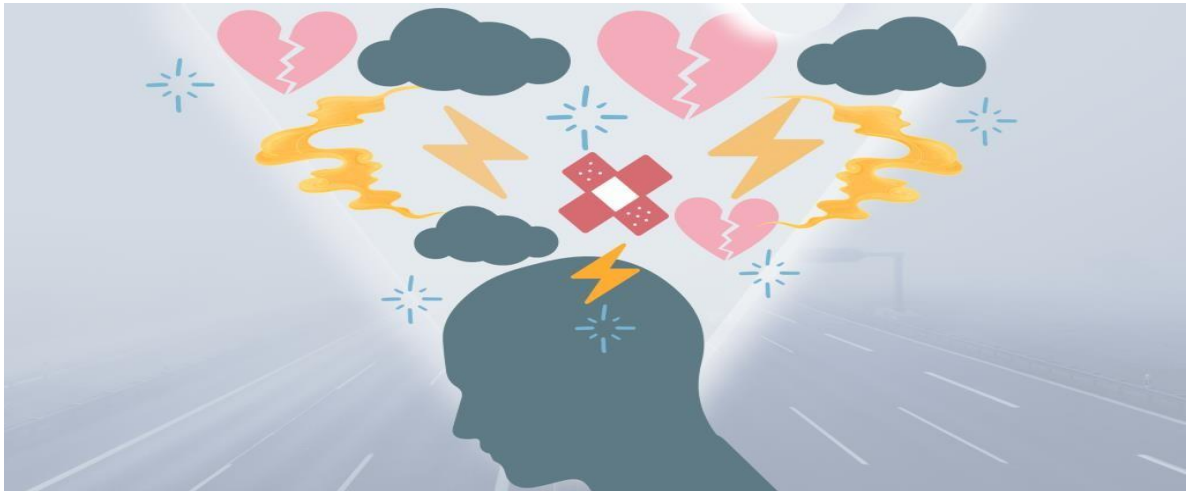
University of East Anglia

Exploring the impact of complex trauma on personal relationships: An Interpretive Phenomenological Analysis

This study is seeking to recruit service users from secondary care mental health teams who have a history of complex trauma events and experience subsequent psychological, emotional, and relational difficulties. We know that people who experience complex trauma difficulties struggle to form and maintain personal relationships. Therefore, the study will explore the impact of complex trauma difficulties on personal relationships, to gather in-depth knowledge and first-hand narratives on these experiences.

We are asking professionals within services to help in identifying potential participants for the study using the inclusion and exclusion criteria. Participants will be asked to take part in an interview that lasts for 60-90 minutes.

It is important that participants have an allocated clinician within the service who will be able to provide support, if needed, throughout the research process. Thank you.



If you know of service users who may be interested in taking part or have questions about the research, please email: c.mangham@uea.ac.uk

University of East Anglia

Inclusion Criteria

Secondary care adult community mental health team service users.

Service users who can be identified by Gatekeepers as eligible for the study using the inclusion and exclusion criteria and their clinical knowledge of service users histories and current difficulties.

Adult service users 18 years +

Service users who identify as experiencing a history of chronic and severe trauma events.

Service users who identify as experiencing a range of complex trauma difficulties including (but not limited to) emotional dysregulation, negative self beliefs/concept, difficulties in relationships, avoidance/emotional numbing, feeling on edge (hyperarousal), and re-experiencing of traumatic events.

Service users who are able to provide full informed consent to take part in the study as per the four principles of informed consent.

Exclusion Criteria

Service users who are currently residing in inpatient mental health services.

Service users in the community who are currently experiencing mental health crisis/elevated levels of risk.

Service users who lack capacity to provide informed consent to participate in the research, including those detained under the Mental Health Act, people who have been diagnosed or service users for whom there are concerns regarding a diagnosis of dementia.

Appendix E: Participant Information Sheet

IRAS ID: 335519
Centre Number:
Study Number:
Version 6: 21/03/2024
Date:

Participant Information Sheet

Project Title: Exploring the impact of complex trauma on personal relationships

You are being invited to take part in our research project. Before you decide whether to participate, it is important for you to know why research is being carried out. This information sheet provides a summary of the research, why it is being undertaken, and what it would involve for you as a participant. Your participation is entirely voluntary. Please read through this information sheet and if you would like any further information, or to ask questions, please get in touch.

Summary

My name is Caroline Mangham. I am a Trainee Clinical Psychologist carrying out research as part of the Doctorate in Clinical Psychology at the University of East Anglia (UEA). The aim of this research is to gain a deeper understanding of the impact of complex trauma difficulties on people's experiences in their personal relationships. The study has been approved by the Health and Social Care Research Ethics Committee A (HSC REC A).

Reasons for the research

We are carrying out this research because we are aware that many people who experience complex trauma events and experience psychological difficulties as a result, face challenges in their close, personal relationships. Despite us knowing that these challenges exist, we believe that there is much more to understand about the ways that people experience the impact of complex trauma difficulties on their personal relationships in their day-to-day lives. We believe that by exploring these matters in-depth, we will gain deeper levels of understanding and meaning.

Why have you been invited?

You have been invited to take part in the research because allocated professionals in your community mental health team have identified that you experience complex trauma difficulties, including difficulties in personal relationships. We intend to recruit eight to ten participants who share these characteristics, all adults, over the age of 18 years.

Do I have to take part?

You do not have to take part in the research – your participation is entirely voluntary. Your NHS healthcare will not be affected if you choose not to take part.

What would be involved by taking part?

If you decided to take part in the research, you would meet with me for an interview that would last for 60-90 minutes. During the interview I will ask questions about your experience of personal relationships and how you feel your relationships are impacted by complex trauma difficulties. The interviews could be held virtually, at your home, or at an NHS site – the time and place of the interview can be decided by you and what fits your personal circumstances best. Once the interviews have

been carried out, I will look at the important factors that emerge, themes, and associated meanings. The results of the research will be shared with the University of East Anglia and Cambridgeshire and Peterborough NHS Foundation Trust and Norfolk and Suffolk NHS Foundation Trust. The research may also be published in an academic journal.

What are the benefits to taking part?

It is anticipated that the results of the research will improve knowledge on the ways that close relationships are impacted by complex trauma difficulties. There is a need for richer, personal accounts of people's experiences which we feel would benefit service users and health professionals through gaining a deeper understanding. However, there are no known individual benefits to participation in the research.

Are there risks with taking part?

You may discuss experiences that bring up uncomfortable emotions during the interview. At any time you will be free to stop the interview, have a break, or change what we are talking about. You do not have to give a reason for doing so. You can choose not to answer any questions that feel difficult. After the interview we can talk through your experience, and I will provide you with a list of organisations that can be contacted for support. You can also speak with your NHS secondary mental health team and General Practitioner for support if needed. If I have concerns about your own safety or wellbeing or that of another person, I will talk this through with you, and this information will be shared with the relevant authority.

Is my information confidential?

When I come to write up the research, I will use a false name that you can choose if you would prefer to do so. Any other information regarding people and places will

also be changed. Direct quotes will be used when writing up the research and every step will be made to ensure that confidentiality and anonymity is respected. Your identifiable information will be stored at the University of East Anglia on an encrypted secure IT system, which will only be accessible by myself and the research supervisors. Face to face interviews will be recorded using a Dictaphone. Secure encrypted software will be used if we meet virtually for the interview (using MS Teams) and to record and store all recordings and transcripts. Recordings will be deleted once they have been transcribed. All information from the interview will be stored with full adherence to the Data Protection Act (2018) and General Data Protection Regulations (GDPR). Other members of the research team (research supervisors) may be able to read the typed interviews once they have been made anonymous.

Personal identifiable information (contact details and consent forms) will be destroyed at the end of the study when these are no longer needed.

How will we use information about you?

We will need to use information from you and your NHS community mental health team for this research project.

This information will include your:

- Initials
- Name
- Contact details

People will use this information to do the research or to check your records to make sure that the research is being done properly.

People who do not need to know who you are will not be able to see your name or contact details.

We will keep all information about you safe and secure.

Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study.

What are your choices about how your information is used?

You can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have.

We need to manage your records in specific ways for the research to be reliable. This means that we won't be able to let you see or change the data we hold about you.

Where can you find out more about how your information is used?

You can find out more about how we use your information:

- At https://www.uea.ac.uk/about/university-information/statutory-andlegal/data-protection
- By contacting dataprotection@uea.ac.uk
- By asking a member of the research team
- By sending an email to c.mangham@uea.ac.uk

Will I be reimbursed for taking part?

There are no financial incentives for taking part in the research. However, as a thank you gesture for your participation, you will receive a £20 Love2shop voucher. If you

travel to a clinical site to take part in the interview, it will not be possible to reimburse for travel costs.

Interview considerations

If you decide to attend the interview at your local mental health team clinical site, it will be important to come into the interview room on your own. However, you are welcome to bring a supportive person to the site and they can wait for you whilst we meet. If you decide to meet virtually or at home, then it will be helpful to make sure you are by yourself so that you can speak freely about your experiences. This also protects your confidentiality.

Can I withdraw from the study?

If you would like to change your mind about taking part in the research, you can withdraw from the interview at any time and in the 14 days following the interview. Any data will then be destroyed and not included in the research. After 14 days the data will have been analysed and therefore it will not be possible to withdraw from the research.

What happens at the end of the research?

At the end of the interview, you will be thanked for your participation and given time to ask further questions, share reflections, and make any additions. Towards the end of the project, you will receive a letter detailing the outcomes of the research. The interview findings will be written up in the form of a Doctoral Thesis that will be submitted to the University of East Anglia; only anonymised data and direct quotes will be used in the report. The research will be shared at the University of East Anglia's post graduate research presentation. The findings will also be shared with

Cambridgeshire and Peterborough NHS Foundation Trust and Norfolk and Suffolk NHS Foundation Trust, and likely written up and published into an academic journal. Future studies may use the anonymous findings from this study to inform further research in this area.

What if there is a problem?

If you are concerned about any aspects of the research or how you have been treated during the study you can contact Professor Sian Coker, Clinical Psychology Doctorate Programme Director at the University of East Anglia. s.coker@uea.ac.uk

Information regarding the formal research complaints procedure at the University of East Anglia can be found at https://www.uea.ac.uk/about/universityinformation/governance/policies-and-regulations/general-regulations/investigatingallegations-of-research-misconduct-students

To make a complaint with your local NHS organisation in relation to the research, please contact:

Cambridgeshire and Peterborough NHS Foundation Trust: palsandcomplaints@cpft.nhs.uk

Norfolk and Suffolk NHS Foundation Trust: complaints@nsft.nhs.uk

Contact Details: If you would like to discuss anything about the research, please contact me on c.mangham@uea.ac.uk . Alternatively, you can contact the research supervisors Lawrence Howells on lawrence.howells@uea.ac.uk and Paul Fisher on p.fisher@uea.ac.uk. Thank you.

Appendix F: Participant Consent to Contact Form

Version 2: 04/03/2024

IRAS ID: 335519 Centre Number:

Study Number:

Version 2: 04/03/2024

University of East Anglia

Consent to Contact Form

Title of Study: Exploring the impact of complex trauma on personal relationships

Name of Researcher: Caroline Mangham

By signing this form, I am agreeing to be contacted for research purposes regarding the above project.

My preferred methods of contact are as below:

Email _____

Text_____

Telephone_____

Other_____

_____	_____	_____
Name of Participant	**Date**	**Signature**
_____	_____	_____
Name of Person taking consent	**Date**	**Signature**

Appendix G: Participant Informed Consent Form

Version 5: 21/03/2024

IRAS ID: 335519

Centre Number:

Study Number:

Version 5: 21/03/2024

Participant Identification Number for this trial:

INFORMED CONSENT FORM

Research Project Title: Exploring the impact of complex trauma on personal relationships

Name of Researcher: **Caroline Mangham**

Trainee Clinical Psychologist

University of East Anglia

Dear Participant,

Thank you for responding to the invitation to take part in the above study. As part of the research process, it is very important that you understand the information about the study as detailed in the Participant Information Sheet and provide written consent for taking part.

Thank you,

Caroline Mangham

1. I confirm that I have read the Participant Information Sheet dated _____, which is attached to this form. I understand what my role will be in this research, I have had time to consider my decision, and my questions have been answered to my satisfaction by the researcher. ☐

2. I agree to the interview being audio recorded by the researcher, for my speech to be quoted anonymously in the final write up and publication. I understand that I can withdraw my consent for this at any time. ☐

3. I understand that my participation is voluntary, and I can withdraw from or stop the interview at any time without giving a reason. I understand that this decision will not affect my healthcare. ☐

4. I understand that the anonymous information collected during the interview may be used to support other research in the future. ☐

5. I understand if the researcher has concerns for the safety of myself or others, they will discuss this with me prior to contacting the relevant authority. ☐

6. I have been informed that all information will be held confidentially and in line with GDPR requirements. I understand that my personal details will not be used in the write up of the study and will not be shared with anyone outside of the research team. ☐

7. I understand that I am free to ask questions at any time before and during the research project. ☐

8. I confirm that I have been provided with a copy of this form and the Participant Information Sheet. ☐

9. I would like to receive a copy of the study results:

YES ☐ NO ☐

In signing this declaration, I am agreeing to take part in the above research project.

_____ _____ _____

Name of Participant	Date	Signature
_____	_____	_____
Name of person taking consent	**Date**	**Signature**

Appendix H: Topic Guide

Version 3: 04/03/2024

IRAS ID: 335519

Centre Number:

Study Number:

Version 3: 04/03/2024

Topic Guide

Project Title: Exploring the impact of complex trauma on personal relationships: An Interpretive Phenomenological Analysis

- Can you tell me about some of your experiences in your personal relationships?
- Can you tell me how you feel your personal relationships have been impacted by complex trauma? (see areas for exploration below)

Areas for exploration:

- How do you feel your personal relationships have been affected by the trauma you have experienced?
- What emotions/feelings do you experience in your personal relationships?

- How do you feel about yourself when navigating your personal relationships?
- What are the most important things you have learned from the impact of trauma on your experience of personal relationships?

Prompts:

- “Can you tell me more about that?”
- “Can you give me an example?”
- “Can you recall a time or experience when this happened?”
- “What was happening then?”

Appendix I: Participant Debrief Form

IRAS ID: 335519 Centre Number:
Study Number:
Version 2: 04/03/2024

Debrief Form

Title of Research: Exploring the impact of complex trauma on personal relationships

Thank you for taking the time to participate in the interview for the above research. Your time is very much appreciated and valued. If you have any questions or comments, please share these at the end of the interview. Alternatively, please feel free to get in touch via phone or email at a later stage.

As discussed, the purpose of the research is to explore the impact that complex trauma events and difficulties have on a persons' experience of personal relationships. It is anticipated that by gaining an understanding of first hand lived experience, we will be better able to understand what relationships feel like for people who experience complex trauma difficulties, which will in turn deepen our knowledge in how best to support people.

You have 14 days to withdraw from the research after the interview has taken place.

At a later stage, I will send a letter detailing the outcomes of the study via your preferred contact method (email/post). This letter will also outline further plans for the

study (including sharing the research within Cambridgeshire and Peterborough NHS Foundation Trust and Norfolk and Suffolk NHS Foundation Trust, and publication in an academic journal). Letters will be sent to all participants.

If taking part in the interview has been difficult and you are worried about your psychological wellbeing, please do get in touch with your allocated professional or duty service within your local community mental health team who provides your mental health care. I have also included a list of services who will be able to provide support:

CPFT Psychological Wellbeing Service
Gloucester Centre
Morpeth Close
Orton Longueville
Peterborough
Cambridgeshire
PE2 7JU
Tel. **0300 300 0055**
Email: selfreferiapt@cpft.nhs.uk
Opening Hours: 09:00 – 16:00, Monday to Friday (closed Bank Holidays)
Web address: http://www.cpft.nhs.uk/psychological-wellbeing-service/

NSFT Wellbeing Norfolk, Waveney & Suffolk
Hellesdon Hospital
Drayton High Road
Norwich
NR6 5BE
Tel. 0300 123 1503
Email: admin@wellbeingnandw.co.uk
Opening Hours: 08:00 – 18:00, Monday to Friday (closed Bank Holidays) Web address: https://www.wellbeingnands.co.uk/

Mind

Mental health charity offering wellbeing advice and support.

Web address: https://www.cpslmind.org.uk/contact-us/

Cambridgeshire and Peterborough Tel: 0300 303 4363

Opening Hours: 09:30 – 17:30, Monday to Friday (closed Bank Holidays)

Norfolk Tel: 0300 330 5488

Opening Hours: 09:30 – 17:30, Monday to Friday (closed Bank Holidays)

Suffolk Mind

Web address: https://www.suffolkmind.org.uk/

Tel: 0300 111 6000

Email: info@suffolkmind.org.uk

Immediate Support

NHS Immediate Response 24 hour Helpline

NHS 111 option 2 is a helpline for people of all ages in Norfolk and Suffolk who need urgent mental health support. The helpline is available all day, every day. Dial 111 and select Option 2

The Samaritans

The Samaritans is a charity that provides emotional support to people in emotional distress, who are struggling to cope or at risk of suicide. The helpline is available 24 hours a day. Tel. 116 123 https://www.samaritans.org/

Shout

Shout 85258 is a free, confidential, anonymous text support service for people in emotional distress or struggling to cope. The text support is available 24 hours a day.

Text: 85258 https://giveusashout.org/

Mind

Web address: https://www.mind.org.uk/need-urgent-help/

Appendix J: Commentary and PET Development Example

Participant	Personal Experiential Themes	Original Transcript	Personal Experiential Statements	Reflective Commentary
Emma	PET: Invalidated by family PET: Survival strategies in relationships. Subtheme: Masking and playing the part with family to avoid further invalidation PET: Survival strategies in relationships. Subtheme: Emma an appeaser and diplomatic in the family.	Emma: So therefore, because I don't speak up… I obviously don't have those feelings because I don't, you know, (gestures as if speaking) so that's probably where it's known that, you know, I'm the, I'm the diplomat because I everybody else at ease and. It's always the case. I can say that now. Yeah, definitely. It is a case of that, and it's always a case of, well, what it's always been, what I feel doesn't matter. Where I am. What what I think about a situation	Emma withholds information and masks in front of her family because they invalidate her experiences Emma is in a diplomatic role within the family Family dismiss and invalidate Emma's mental health difficulties and needs Invalidation and dismissal from family has caused a lot of damage to Emma's self worth	Emma talks about the interpretation that family make about her - people assume that she doesn't have those feelings, because she doesn't speak up – a constant experience of silencing and being silenced. Family relationships, their responses all impact her mental health but not speaking up is safer. Emma manages everyone elses' feelings, and in doing so also regulates her own to a certain extent... I feel a sense of injustice for Emma. Reiterating the point - this is relevant and hurtful for Emma - her position in the family and the invalidation she experiences. She is immediately discounted so

	PET: Invalidated by family	doesn't matter. Everybody else will make their self known. So and in the past, I've always been told, you know, like I say, you're making a mountain out of a molehill.	Emma withholds information and masks in front of her family because they invalidate her experiences	has moved into the position of not expressing. This seems to form an established relational dynamic.
	PET: Survival strategies in relationships. Subtheme: No relational framework for friendships	Interviewer: Has that impacted your other relationships? The role that you've played within the family? I can't think of any other relationships that.. I don't have a particularly wide group of friends… I'm not a friend's person. The idea of people having friends that they rely on and share everything with, you know, people say, “oh, so	No relational framework for close friendships	I explore how these experiences may have affected other relationships and Emma then moves on to give a rationale about friendships (doesn't relate this to husband, husband feels like a different relationship). ‘I'm not a friends person’ - this feels completely alien, something that Emma can't relate to. I wonder if this is impacted by her earlier life experiences, family relationships and

	PET: The power of human connection. Subtheme: Husband as a rock, protector and saviour	and so she's my girlfriend and we share everything". And I'm like, that concept is lost on me. Interviewer: Mm hmm. OK. Emma: The idea of having that kind of a close relationship with anybody is lost on me. I suppose except my husband… But outside of him. Not got anybody that I can particularly say that I have any real closeness to. Interviewer: What is it about the close friendship that makes you feel lost? Emma:	The marriage with Emma's husband is secure and safe No close relationships outside of the relationship with her husband	trauma. Emma also seems quite introverted. Engaging in pseudo relationships with family that are not authentic. How can she take this framework and apply it to relationships that she doesn't have and would have to build? Linguistic – 'concept is lost on me' - like it literally makes no sense, .. Her circle is small - does this speak to trust or lack of framework or desire? Very small system, dependence on her husband? Closes her off to other opportunities for friendships... but sounds like she doesn't miss what she never had? She is only close to her husband. I wonder if this is linked to

	PET: Survival strategies in relationships. Subtheme: Trust difficulties and isolation from potential friendships PET: Complex trauma difficulties. Subtheme: Experiencing feelings feels sick and uncomfortable PET: Survival strategies in relationships. Subtheme: Trust difficulties and isolation from potential friendships	Letting someone in, I think… Feels really, I'm sitting here now. It feels really untrustworthy, Actually. The idea that I would trust somebody with anything about me or my feelings, you know that word (mimicks sick). Yeah, yeah, that word... Interviewer: The F word. You can call it if you feel better. Emma: Yeah. Trust. Yeah. I don't know that I could trust anybody with with that, as a concept. And not just trusting them to keep it to themselves. Actually to…. Kind of believe it. I don't know. Or yeah, I don't. I don't know. Just anything to do with it, to be honest	No relational framework for close relationships Lack of trust in others No close relationships outside of the relationship with her husband due to lack of trust Feelings make Emma feel sick and uncomfortable Lack of trust in others No close relationships outside of the relationship with her husband due to lack of trust	CT, but also personality, lack of trust in others etc... no map for navigating this.. Description of untrustworthy feels very strong and definite. So we come back to trust here - underpinning the dearth of other relationships in her life, they feel like a big risk. - sounds like she hasn't been forced to think about this before but now there is a realisation... Linguistic - it feels really untrustworthy - unsafe, people can't be trusted, this links to openness and sharing. Not something that has been safe with the core relationships in her family Linguistic – 'as a concept' - trust as a general thing, beyond simple interpretations of not being a gossip but goes

	PET: Survival strategies in relationships. Subtheme: Trust difficulties and isolation from potential friendships	with you. Yes, that's that's…. Interviewer: Can you think of a time where you ever have had a friend or a friendship and it's felt uncomfortable. Emma I've Not let anybody that close.	Lack of trust in others Safety in maintaining distance from others Strong boundaries	further into being validated and held in safety with her authentic difficulties - most likely linked to complex family relationships. There is no level of trust that could be afforded. Immediate response, there feel like boundaries and barriers to keep people away to maintain her personal safety and not take relational risks.

Appendix K: Developing Group Experiential Themes Example

Personal Experiential Themes	Quotes	Group Subtheme	Group Experiential Theme
PET: Survival strategies in relationships. Subtheme: Trust difficulties and isolation from potential friendships PET: Survival strategies in relationships. Subtheme: Trust difficulties and isolation from potential friendships PET: Trauma and grief related interpersonal behaviours. Subtheme: Problems with trust and affection with others	"Letting someone in, I think… Feels really, I'm sitting here now. It feels really untrustworthy, Actually. The idea that I would trust somebody with anything about me or my feelings, you know that word (mimicks sick). Yeah, yeah, that word... Trust. Yeah. I don't know that I could trust anybody with with that, as a concept. And not just trusting them to keep it to themselves. Actually to…. Kind of believe it. I don't know. Or yeah, I don't. I don't know. Just anything to do with it, to be honest with you. Yes, that's that's…. I've Not let anybody that close". (Emma). "Its trust, I don't I don't trust anybody. That's what it is. I don't trust no one…	Self preservation and protection	Challenges in relationships

	Janet: Yeah. Yeah. No trust. No trust in nothing. The Worse things happen and I used to say to him, we gonna are we gonna have any good luck?" (Janet).		
PET: The impact of complex trauma on relationships in the present day. Subtheme: Suspicion around the motives of others due to lack of trust	"So with my mom, if she had done something that was not nice or she had been particularly horrible, she had hurt me in some way. Then there would be a present, that would be the new toy that I wanted. That would be money in a little envelope, pushed under my door, when I was ten years old… and it meant that like the first time that Jess bought me a present just out of nowhere, I was like, "what have you done"? "What's going on"? "What do you need to tell me"? And there was a lot of Jess being like she bought.. I think it was for national coming out day.		

	She bought me my first pride flag. And was like “its just because it's national coming out day. And because I love you and I thought you would like it”. And I was like, I don't. I couldn't trust that that was the truth, and it took maybe two weeks for me to be like, oh, no, there actually isn't anything that's coming with this. There isn't gonna be a cost for this”. (Green).		
PET: CPTSD is Mary’s superpower. Subtheme: Hypervigilance from complex trauma keeps Mary safe.	“In fact, the chap that's told me he was separated and wasn't. The last message he sent to me was. “It's such a shame that your PTSD kicked. It kicks in all the time”. Because you know, and I can't remember what he finished with. And I went back to him and said “it's my cptsd that keeps me safe from wankers like you”. Sorry about that… that's exactly what I said to him. “That's what		

	keeps me safe from wankers like you". (Mary).		
PET: Trauma and grief related interpersonal behaviours. Subtheme: Cutting people off	"I just. I just didn't want to talk to nobody. I didn't. Avoidance. That's what Sarah said. It's avoidance. You know, I just… Hide away, just in my bedroom. Kept out the way, Tristan just left me to it. I just didn't wanna be around anybody. Couldn't. I never went anywhere and never done anything. And then. I just woke up one day and I thought I can't carry on like this, you know, it was really doing my head in. Pushing everybody away, I had nobody, But I felt I've had nobody anyway because I was orphaned". (Janet).		