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**Exploring the Experience of Shame in Adult Survivors of
Childhood Sexual Abuse Using a Mixed-Methods
Approach**

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Declaration

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Summary

Childhood sexual abuse (CSA) is a worldwide problem that increases survivors' likelihood of experiencing a range of physical and mental health conditions. Survivors often feel, or are made to feel, shame surrounding their experiences. These feelings of shame appear to play a role both in negative health outcomes as well as other elements of the experience, such as discouraging disclosure. Yet much remains to be understood about how and why shame has these effects.

This thesis first provides some general background on CSA, including a discussion of global prevalence rates of CSA, and a description of short- and long-term somatic and psycho-social outcomes of CSA. The Irish historical and cultural context relevant to the current programme of work is then discussed, along with theories of shame in non-clinical and clinical contexts.

Chapter 2 then reports the results of a pre-registered study that undertook a systematic review of the existing research on shame in the context of CSA, building on the recommendations of the scoping review of MacGinley et al., (2019). Out of the 168 studies selected for final analysis, 81 were quantitative, 81 were qualitative, and six were mixed-methods studies. The Results section analyses the quantitative and qualitative findings separately, with the Discussion section drawing these findings together and making recommendations for future research. Major themes that emerged from the body of research on this topic are: the negative effects of shaming experiences on survivors' desire to disclose CSA; the all-encompassing nature of shame in survivors; the mediating effect of self-compassion in the relationship between shame and adverse outcomes; the role of self-compassion and therapy in mitigating shame; and the lack of appropriate and dedicated ways to assess levels of shame in survivors.

Next, Chapter 3 reports the results of a quantitative online questionnaire-based study, which recruited survivors of CSA from counselling/support services and social media support groups. Participants completed measures of general shame, trauma-related (i.e. CSA-related) shame, trauma-related guilt, self-compassion, PTSD, and depression. Complete datasets on these variables were obtained for 37 participants. Hypothesised models of relations between PTSD and CSA-related shame were tested using linear multiple regressions, testing for the role of self-compassion as both a mediator and moderator. In addition to discussing the patterns of findings, issues encountered during recruitment and lessons learned from this for future work are discussed. Though no significant mediating or moderating effects were found in these

regressions, significant correlations were found between CSA-related shame and a number of the outcome measures investigated, including a negative correlation with self-compassion, and positive correlations with general shame, PTSD, and depression. In addition, a direct effect was found in a regression between CSA-related shame and PTSD.

Chapter 4 reports on the results of a qualitative study that conducted in-depth semi-structured interviews with survivors of CSA (n=2) and service providers at an Irish psychological clinic and a service supporting migrant women(n=3), examining the presence, role, and influence of shame in CSA. Both survivors of CSA had undergone psychological therapy and their interviews were analysed separately, to respect the uniqueness of each account. Interpretative phenomenological analysis was performed on the survivor interviews due to the small sample and the heterogeneity of their accounts, while general thematic analysis was performed on the service provider interviews due to the greater homogeneity of these accounts. In addition to insights gained from the content of the interviews, lessons learned from the process of recruitment are also discussed. Some major themes that emerged from the interviews are: the inseparability of shame from the survivors' sense of self; the deep impact of systemic failures to respond to survivor disclosures and suspicions of abuse; the impact of familial and community reactions to the abuse on survivor shame; and the role of self-compassion in reducing shame within a therapeutic context.

The thesis then concludes by knitting together the findings from the three empirical studies. This section provides a high-level synthesis of what is known about shame and CSA, points to new avenues of future research, and suggests systemic, socio-cultural, and clinical changes to help prevent or mitigate shame in survivors.

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*‘The soil is bad for certain kinds of flowers. Certain seeds it will not nurture,
certain fruit it will not bear.’*

— Toni Morrison, *The Bluest Eye*

‘Word is not the privilege of some few persons but the right of everyone.’

— Paulo Freire, *Pedagogy of the
Oppressed*

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Chapter 1: Introduction

1.1 Global Prevalence, Manifestations, and Common Outcomes of Childhood Sexual Abuse

Childhood sexual abuse (CSA) is one of the most devastating forms of adverse childhood experiences (ACEs), affecting children across the world (Barth et al., 2013; Stoltenborgh et al., 2015; World Health Organisation, 2022). Though it is difficult to ascertain accurate CSA prevalence statistics, for reasons discussed below, the World Health Organization (WHO) estimates that one in five women (20%) and one in thirteen men (7.6%) has reported being sexually abused in some way during childhood. Furthermore, around 120 million women and girls younger than 20 years of age have experienced forced sexual contact (World Health Organisation, 2022). A 2015 review of meta-analyses involving 217 studies on the global prevalence of CSA, showed estimates of prevalence between 11-21% in girls and 4-19% in boys (Stoltenborgh et al., 2015), roughly consistent with the WHO prevalence rates. According to this Stoltenborgh et al.'s review, the highest rates for girls and boys were reported in Australia and Africa respectively. Another review on the global prevalence of CSA (Barth et al., 2013), which analysed 55 studies from 24 countries, found a 8-31% prevalence rate in girls, and 3-17% rate in boys, largely confirming other statistics and reviews on the topic.

There is consensus in the CSA and child maltreatment research that the true prevalence of CSA is likely much higher than indicated by these reported statistics (e.g., Barr et al., 2017; Singh et al., 2014). This is due to a persistent lack of registration by local authorities of reports of CSA, underreporting by victims as a result of cultural stigma, shame, or fear of retribution, differences in legal and socio-cultural definitions of CSA, and varying methods of data collection, among other factors (Stoltenborgh et al., 2015; World Health Organisation, 2022). Moreover, while statistics seem to show that girls are more often victims of CSA than boys, this may be due to the harsher attitudes and stigma many societies have against male victims of sexual abuse, thereby discouraging boys from coming forward and reporting CSA, or perhaps leading them to not view

their experience as abuse in the first place (Dubowitz, 2017; Stoltenborgh et al., 2015; World Health Organisation, 2022).

The form that CSA takes can vary greatly, as it is influenced by factors such as the age and gender of the victim, their relationship to the abuser, and their cultural and societal context. The standard definition of CSA used globally in clinical and legal contexts, involves an adult or older adolescent (someone with some type of power or authority over a child) exploiting a child for sexual gratification (Rape, Abuse, and Incest National Network, n.d.). In the majority of CSA cases, the abuser is a trusted authority figure or guardian of the child, such as a family member, family friend, or other adult known to the child (Rape, Abuse, and Incest National Network, n.d.); this can consequently make it difficult for the child to recognize and disclose the abuse to others. However, according to a recent report by the National Police Chiefs Council in the United Kingdom, in 2022 52% of reported sexual offences against children in England and Wales had been perpetrated by other children (aged 10-17), mostly peers, though it was also noted in this report that adult offences against children were generally more severe, and that the highest risk was still for abuse by adults within the family (Symonds, 2024).

The nature of the exploitation can range from non-contact abuse, such as exposure to sexual acts or materials, to contact abuse, which includes fondling, penetrative (or penetrating) rape, and other forms of sexual assault. In the past few decades, and since the COVID-19 pandemic in particular, online and virtual sexual abuse have also increased significantly, changing the landscape and appearance of CSA in many instances (altering what 'non-contact' abuse means, for example) (Organisation for Economic Co-operation and Development, 2023). Societal conceptualisations and legal definitions of CSA also differ, thereby leading to some acts and phenomena being categorised as CSA in some regions of the world but not others. This is highlighted in a recent global survey of CSA experts by leading child abuse organisation ISPCAN (International Society for the Prevention of Child Abuse and Neglect), which aggregated data on the status of CSA and CSA-related attitudes and legislation in 73 countries (Dubowitz, 2017). While

there was agreement between most regions and socio-economic strata that sexual acts involving parents towards their child constituted CSA, there was less consensus when it came to other types of CSA. For instance, 35% of respondents representing the Americas indicated that child marriage was widely considered a form of CSA in their countries, while this number was 85% for respondents from Africa and Asia (perhaps this is due to the prevalence in recent decades of anti-child marriage campaigns in many parts of Africa and Asia). Similarly, when it came to the sex trafficking of children (labelled as 'prostituting a child' in the study), 100% of respondents from the Americas and Oceania indicated that this was widely considered CSA in their countries, but in other regions, this percentage was lower (e.g., 85% in Africa). It is worth noting however, that because the respondents are regional experts (academics and NGO workers) reporting on what they see as their countries' prevailing opinions on CSA, it is difficult to determine if the respondents' answers were also trying to reflect what their national laws considered CSA, or whether the respondents might have felt the urge to represent their countries in a more favourable light.

Generally, the impact of CSA is wide-ranging, profound, and long-term, affecting survivors emotionally, socially, behaviourally, cognitively, physically, and sexually (Sanderson, 2006). One of the most common intrapersonal (emotional) outcomes observed in survivors by clinicians, is what Sanderson terms a 'shattering of the self', characterised by a destruction of the child's sense of self by the abuser, difficulty in self-definition, and low self-worth, which often leads to a lifetime dependence on others for self-validation and identity formation (Jurist, 2019; Sanderson, 2006). This destruction of self and self-worth is intrinsically linked to survivors' experiences of shame, which is discussed later in the introduction and in subsequent chapters of the thesis. Difficulties in affect and emotion regulation are also common in CSA survivors, as a result of the children often being deprived of affection, comfort, or self-regulation skills by the abuser and/or guardians. Impaired emotion and affect regulation in children with CSA histories have been linked to the

development of other adverse outcomes, such as increased post-traumatic stress disorder (PTSD) and depression levels, various internalised and externalised behaviour problems, withdrawal in social interactions, and sensitivity to stress (Amédée et al., 2019; Chang et al., 2018; Hébert et al., 2018; Yaroslavsky et al., 2022). Specifically, the mediating effect of emotion regulation has been studied in depth in the context of CSA; Hébert et al. (2018) found children's emotion regulation abilities to mediate the relationship between cumulative childhood trauma and behavioural problems in school, while Yaroslavsky et al. (2022) demonstrated a sequential mediation effect involving emotion regulation, such that CSA history predicted deficits in emotion regulation and in turn, emotion regulation deficits predicted the effects of stress on depression.

In terms of common psychosocial and cognitive outcomes of CSA survivors, an umbrella review analysing 19 meta-analyses (559 primary studies) by Hailes et al. (2019) found strong associations between CSA history and long-term depression, PTSD, borderline personality disorder (BPD), conversion disorder (CD), schizophrenia, and substance misuse; the quality of evidence for PTSD, schizophrenia, and substance misuse were noted as being the highest. Another review of reviews by Maniglio, from 2009 (14 systematic reviews; 587 primary studies) found CSA history to be commonly associated with PTSD, obsessive-compulsive disorder (OCD), depression, psychosis, dissociation, somatisation, BPD, suicidal and self-injurious behaviour, eating disorders, sexual dysfunction and high-risk sexual activity, revictimisation, and substance misuse. The effect sizes of the associations identified in this review vary greatly due to the vast differences in sample characteristics and the outcomes investigated; PTSD and revictimisation risk showed stronger associations with CSA histories than eating disorders, unprotected sex, and learning impairments, for example.

Somatic symptoms are particularly common in survivors, and seem to have a link to the way trauma activates the body's stress response over time. According to Kendall-Tackett (2011), chronic pain is an extremely common complaint of CSA survivors; while the pain is often centred around the pelvis and other parts of the body that were involved in the abuse, it is also common

for the pain to be more generalised and take hold all over the body. A high percentage of those diagnosed with fibromyalgia (widespread musculoskeletal pain) and irritable bowel syndrome report a history of CSA. It is speculated that these experiences of pain in survivors are due to chronic inflammation in the body, a direct result of the body's stress response (which is activated on a long-term basis by the trauma) (Kendall-Tackett, 2011). A study of adult survivors of child maltreatment showed elevated levels of C-reactive protein, a biological marker of inflammation, over 20 years after the abuse stopped, independent of other stressors in the participants' lives (Danese et al., 2007). The same study also found elevated levels of white blood cell count (a downstream effect of the immune response), in survivors of CSA or childhood physical abuse; the severity of the abuse was positively correlated with the levels of C-reactive protein and white blood cell count. Elevated C-reactive protein and proinflammatory cytokine levels (another inflammation marker) were also found in female rape victims 24-72 hours after their assaults (compared to a control group) in Groer et al. (2006), providing additional evidence for the short- and long-term physiological effects of CSA.

Finally, dissociative symptoms appear in a large portion, if not the majority, of CSA survivors; research shows the long-term cascading effects that these symptoms have on many aspects of survivors' lives. The Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR) characterises dissociation as 'a disruption of and/or discontinuity in the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control, and behavior' (American Psychological Association, 2022, p. 330). While dissociation can often be a coping mechanism for children during the period of abuse, it also follows survivors post-abuse, in the form of amnesia, continued experiences of dissociative states and dissociative disorders, and more (Sanderson, 2006). Similar to what is seen with chronic pain and inflammation, studies have shown high rates of CSA histories among people reporting dissociative symptoms.

When it comes to children, Ensink et al. (2017) demonstrated a core mediating role of dissociative symptoms in the relationship between CSA history and internalising, externalising,

and sexualising behaviour in 138 children ages 2-12 years, compared to non-abused children—an association that was also demonstrated by Hébert et al. (2018). Associations between dissociative symptoms and an increased risk of attention problems (Kaplow et al., 2008), emotion regulation problems (Hébert et al., 2018), suicidality, and self-mutilation (Kisiel & Lyons, 2001) have also been found; in the latter study, dissociation seemed to have a mediating role between psychiatric symptoms and risk-taking behaviour.

In the case of adult survivors, in a study of female college students with (n=175) and without (n=266) CSA histories, higher mean scores were found for those with CSA histories on measures of dissociation as well as self-destructive behaviours (Rodriguez-Srednicki, 2001), with dissociative symptoms mediating the relationship between CSA history and drug and alcohol misuse. Dissociative amnesia (DA) has been observed in many CSA survivors, given that lapses of consciousness and memory encoding are inherent facets of the dissociative experience (Wolf & Nochajski, 2013); the consequences of DA can extend to problems regarding the ability to disclose the abuse (due to lacking a cohesive memory of the abuse), and doubt in one's own memory (linking back to many survivors not having an integrated and defined sense of self). To the survivors, this would in turn validate any negative messages encountered in their environment regarding their intellect or other aspects of their mind, potentially resulting in a feeling of shame. Certain factors seem to pose a higher risk for developing DA in CSA survivors; these include age (the younger the survivor is at the time of abuse, the more likely they are to develop DA, even when infantile amnesia was taken into account), the relationship of the survivor to the perpetrator (the closer the relationship, such as familial, the higher the chance of DA), frequency/duration of abuse (the more frequent, the higher the DA risk), and severity of the abuse (the more severe, the higher the risk of DA) (Wolf & Nochajski, 2013).

Importantly, for the purposes of this thesis, dissociation has also been seen in conjunction with the trait of being prone to feeling shame (known as shame-proneness) in survivors. For example, in a sample of 99 female inpatients at a psychiatric hospital, higher levels of shame-

prone to shame were associated with higher levels of dissociation, with shame-prone individuals acting as a significant predictor of dissociation in the study's regression model (Talbot et al., 2004). Given the myriad impacts of long-term dissociative symptoms on the lives of survivors, studying its link to shame and the causal direction of this relationship is paramount.

1.2 CSA in Ireland: Historical Context and Current Prevalence

1.2.1 Historical Context of CSA in Ireland

The prevalence of CSA in pre-Christian Ireland is not known with any accuracy, largely due to the pre-literate nature of societies at the time. However, it is reasonable to assume the existence of CSA and other types of child abuse in that period and before, based on archaeological evidence. For instance, remains of children were regularly found alongside the cremations of adults in sites dating back to 1,200-200 BC—these are speculated to have been a form of child sacrifice, believed to help the adult pass more quickly into the afterlife (Lalor, 1998).

The first written accounts relating to CSA in Ireland seem to have emerged around the 6th century in early Christian Ireland with the publication and distribution of the Penitentials, a manual for clergy members containing 'exhaustive lists of proscribed behaviours,' and which 'recommended the appropriate penance for offenders' (Lalor, 1998, p. 4). Among the prohibited behaviours listed in this manual were incest, as well as 'misuse' of one's child, which is interpreted as alluding to sexual abuse (Bieler, 1963; Lalor, 1998). Some potential evidence for victim-blaming in the context of CSA (a possible avenue for the development of shaming practices), may also be found in the Penitentials, in a section suggesting that 'misused' boys must undertake penance (Lalor, 1998). The Celtic Brehon Laws of the 7th and 8th centuries may offer further insight into how CSA was viewed and dealt with at the time. Analysis of these laws indicated that children were highly valued and protected by the law in some ways—for example, the penalty for injuring a child aged seven or younger was equivalent to the penalty of hurting a cleric (Kelly, 1988; Lalor, 1998). Another law referencing CSA (though not framed as such) allowed for a wife to divorce her husband if he was having sexual relations with a 'boy or man' (Lalor, 1998). Beyond this

however, there is currently no surviving documentation of practices relating to CSA from this far back in Irish history.

Jumping forward to the 19th and 20th centuries, we see the gradual development of the child protection system in Ireland against the backdrop of occupation by the British, as well as the growing influence and authority of the Catholic Church. 1889 saw the establishment of the National Society for the Prevention of Cruelty to Children (NSPCC), which became the Irish Society for the Prevention of Cruelty to Children (ISPCC) after independence, in 1956 (Buckley et al., 1997; Lalor, 1998). In 1908 the Punishment of Incest Act was created, marking the first instance of the criminalisation of incest in modern Ireland. In the same year, the Children Act came into being as a way to offer legal protections to children from poor or otherwise socially disadvantaged backgrounds, signalling a change in the way certain sections of society viewed and treated children (i.e. acknowledging 'childhood' as a separate category from 'adulthood', one that required extra protections.) (Buckley et al., 1997). Within this act, 'allowing children or young persons to be in brothels' and 'causing, encouraging, or favouring seduction or prostitution of a young girl' (note that this offence did not cover boys) were listed as offences (Children Act, 1908, p. 1).

Despite the existence of the N/ISPCC during this period, CSA did not receive much attention on a national or legal level, though it is known now that sexual abuse was rampant in residential schools and workhouses, as well as in other religious settings, throughout the 1800s and 1900s. Investigations into institutional CSA started to gain traction only in the 1980s, after the Department of Health published a report following an investigation into 'non-accidental injury to children' in which several cases of institutional sexual abuse were identified (The Law Reform Commission, 1990). The report heralded an era of unprecedented claims of historical CSA, prompting further investigations into religious and institutional abuse and importantly, paving the way for the development of the Child Care Act of 1991.

The new Child Care Act updated and recontextualised child protection laws (which until then were still largely taken from the Children Act of 1908) according to the guidelines

recommended by the 1990 Report on Child Abuse. Among their recommendations were: the involvement of the Gardaí (Irish police force) in cases of CSA to facilitate potential prosecution; the ability to seek barring orders to remove abusers from the homes of the victims; and the development of a child-friendly court system involving special training for the judiciary (Buckley et al., 1997; The Law Reform Commission, 1990). Crucially, the Child Care Act of 1991 entrusted the State (via the Health Boards) with primary responsibility for the welfare of children not otherwise receiving proper care, and gave these Health Boards (along with the Gardaí) power to intervene in cases of child abuse and neglect. Laws surrounding the inspection of residential centres were also updated and strengthened (Buckley et al., 1997; Child Care Act, 1991). Further revisions and iterations of the Child Care Act, and the introduction of the Child and Family Agency Act of 2013 eventually resulted in the creation of Tusla-Child and Family Agency in 2014, over 20 years after the publication of the first Child Care Act in 1991. Today, Tusla acts as the State agency responsible for children's welfare, and is responsible for responding to reports and cases of CSA along with the Gardaí and other relevant state departments (*Tusla - Child and Family Agency*, n.d.).

While the Child Care Act has ushered in a more hopeful era regarding the protection of children from sexual abuse, the spectre of Ireland's tragic history of institutional abuse still hangs over the country as it tries to reconcile with the victims of these abuses and their surviving family members. In the few decades preceding and following independence, Ireland's societal structure was greatly shaped by the Catholic Church, which wielded considerable authority in many aspects of daily life, including in education and care institutions. During this time, thousands of disadvantaged children, as well as so-called 'fallen women' (i.e. women who were pregnant and unmarried, or considered 'disobedient' in some other way, and some of whom were victims of CSA) were placed in institutions such as industrial schools, reformatories, and, perhaps most infamously, mother and baby homes. Most of these institutions were run by religious orders such as the Christian Brothers and Daughters of Charity, with the purported goal of giving these children and women a safe refuge in which to develop themselves, give birth, etc. (Hogan, 2020). In reality,

abuse of all kinds, as well as the death of around 9,000 children due to illness and negligence, occurred within these institutions—but a collective culture of shame, largely inculcated by these same religious orders, served to prevent survivors of these abuses, and their families, from speaking out (Hogan, 2020).

As Hogan further describes in her book *Republic of Shame*, ‘None of the building blocks of the shame-industrial complex was intrinsically Irish or intrinsically Catholic. But independent Catholic Ireland brought them to a sort of dark perfection.’ (Hogan, 2020, Chapter 3). Hogan paints a nation burdened by the fear of the consequences of immorality and sin, one in which ‘poverty and shame drove parents to kick out their own daughters if they became pregnant,’ as one nun working for the Daughters of Charity explained. But, as Hogan rightly asks, ‘where did the shame come from?’ (Hogan, 2020, Chapter 1). While several systemic factors would have contributed to the ‘shame-industrial complex’, such as the conflation of Church and state, gender-segregated schooling, high rates of poverty, and Catholicism being a major source of community in the face of an occupying force, it is also worth probing in the future some of the fundamental aspects of organised Catholicism itself (in the broader context of organised religion and other influential hierarchical groups involving children, such as Boy Scouts/Girl Guides) to begin elucidating how shame came to be such a central force acting on so many, for so long.

The scale and severity of CSA in religious institutions began to emerge in the 1980s and 90s, as mentioned above. The reports resulting from the state-led investigations into the abuse, namely the Ferns, Ryan, Murphy, and Cloyne reports laid bare the extent of the abuse, and the subsequent attempts at covering up the atrocities, protecting the abusers, and silencing the survivors. They revealed systemic sexual abuse by clergy members and highlighted the failures of the state and the Church to protect the most vulnerable children when abuse was suspected.

The Ferns report, published in 2005, identified ‘over 100 allegations of child sexual abuse made between 1962 and 2002 against 21 priests’ in the Diocese of Ferns alone (Buckley et al., 2005, p. 2). The response of bishops in the diocese when made aware of allegations of CSA varied

throughout these several decades, often following prevailing cultural and medical stances towards CSA as well as bishops' personal management styles. Between 1960 and 1980 (Bishop Donal Herlihy's tenure), it was standard practice for priests accused of CSA to be temporarily reassigned to a different diocese; this was considered appropriate and proportional punishment for their alleged abuse. In many instances the accused priests were brought back to their original positions eventually, having apparently experienced enough of a penalty for what the bishop primarily considered 'a moral problem.' It was also found that several priests ordained by Bishop Herlihy had known histories of inappropriate behaviour with children (Buckley et al., 2005). A new Bishop was appointed in 1984 (Brendan Comiskey); the Ferns inquiry found Bishop Comiskey to have been equally ineffective in addressing cases of CSA, and in particular, failed several times to 'persuade the priest in question to vacate his position and undergo the assessment and treatment suggested' (Buckley et al., 2005, p. 2).

The Ferns report goes on to acknowledge the genuine attempts of the Gardaí and the South Eastern Health Board (created in 1970) to investigate reports of clerical CSA that reached them, while highlighting the obstacles they faced trying to do so. The South Eastern Health Board was greatly limited in their response to CSA allegations by a lack of 'statutory powers[...]where the welfare of the child is endangered by abuse perpetrated by persons outside the family circle' (Buckley et al., 2005, p. 4), which meant that they could not intervene here in the same way they could have in cases of familial CSA. This may have been worsened by a lack of knowledge of the Board's statutory powers by some of the staff involved at the time (Buckley et al., 2005). As mentioned above, laws widening the remit of the Health Boards in cases of abuse and neglect were only put in place in the 1990s.

When it came to the conduct and effectiveness of the Gardaí in investigating the eight complaints of Church-related CSA brought to them, the report judged that the majority of cases were handled in 'an effective, professional and sensitive manner', while the handling of one case was 'wholly inadequate' (Buckley et al., 2005, p. 3). Out of the six official cases referred to the

Director of Public Prosecutions, two convictions were ultimately made. It was also noted that prior to 1988, a few complaints about priests made to Gardaí in the area were not recorded; the commission was unable to comment definitively on why this might have been, but suggested an unwillingness to pursue higher-ups in the Church as a potential reason. The conduct of the Gardaí in relation to clerical CSA cases post-1990 was found to have not been inhibited in any way, indicating crucial cultural and administrative-level changes in the way CSA was starting to be handled.

In 2002, following the resignation of Bishop Comiskey after his failures at child protection were made public, the Diocese of Ferns appointed a new Apostolic Administrator (Bishop Éamonn Walsh). It was during this period that practices relating to child protection were made stricter and more effective, according to the report. All outstanding CSA allegations were reviewed, and a new Advisory panel was set up to investigate these and other cases. Appeals were made for more victims to come forward, to which there were significant responses. At the time of the Ferns Report's publication, the committee deemed the practices of the Diocese of Ferns in relation to CSA and child protection to be satisfactory, and operating 'at a very high level' (Buckley et al., 2005, p. 3).

The initiation of the Ferns Report spurred similar State investigations into the handling of CSA cases in other clerical regions of Ireland, such as the Murphy report, which investigated allegations of clerical sexual abuse in the Archdiocese of Dublin from 1975-2004. The findings of this report were, as expected, similar to those of the Ferns Report. The report was clear in stating that when it came to dealing with CSA allegations, clergy members acted in the best interests of the Church at the expense of the victims, and that it was not possible that their claims of not being aware of these allegations/occurrences of abuse could have been true (Murphy et al., 2009).

Allegations of CSA against 102 priests in the diocese were examined as part of the investigation, and the cases of 46 of those priests (involving 320 victims) were exemplified as part of the final report; 11 of these priests were convicted of or pleaded guilty to CSA in criminal court.

Despite these few successes with regard to the Gardaí's conduct, the report also highlighted the failures of the police in handling clerical CSA. Particularly in the earlier period of the investigation, it was found that many Gardaí thought of 'priests being outside their remit' (Murphy et al., 2009, p. 24), and that 'There are some examples of Gardaí actually reporting complaints to the Archdiocese instead of investigating them' (Murphy et al., 2009, p. 24). The inappropriately informal relationship between many members of the Gardaí and the Church throughout much of the 1960s, 70s, and earlier was flagged as a major reason the abuse was allowed to continue unpunished.

Among other major findings of the Murphy report, was that adherence to the oath of pontifical secrecy, formerly a central tenet in the practice of Roman Catholicism, was commonly used as justification by members of the Archdiocese for their inaction in the face of CSA allegations, and the main reason that the Gardaí were not informed of any allegations until 1996. Pontifical secrecy refers to 'the duty of clergy and church officers not to report, or comment on, facts and events of a confidential nature that they have come to know in the exercise of their office' (Pirson, 2011); this was commonly interpreted by Catholic clergy members as including confessions of criminal acts such as CSA. The obligation to maintain this rule of secrecy was also found to have been imposed on persons bringing forth complaints of CSA, such as parents of the victims (Murphy et al., 2009).

While the oath of secrecy was ideally meant to engender trust in the Church and prevent communal discord, it has in fact proven extremely detrimental to that very goal in recent decades. The oath was only recently, in 2019, officially abolished (for investigations of CSA) by Pope Francis, in light of the tremendous global outrage towards the Church caused by reports such as the ones above (Pullella, 2019). Another consequence of this decision was that internal Church communications and meetings relating to CSA cases under police investigation would no longer be afforded the privilege of being kept secret (Pullella, 2019).

The Murphy Report ultimately concluded that:

'As can be seen clearly from the case histories, there is no doubt that the reaction of Church authorities to reports of clerical child sexual abuse in the early years of the Commission's remit was to ensure that as few people as possible knew of the individual priest's problem. There was little or no concern for the welfare of the abused child or for the welfare of other children who might come into contact with the priest. Complainants were often met with denial, arrogance and cover-up and with incompetence and incomprehension in some cases. Suspensions were rarely acted on. Typically complainants were not told that other instances of child sexual abuse by their abuser had been proved or admitted.' (Murphy et al., 2009, p. 10)

The culture of secrecy within the Church, and the shaming that resulted from the violation of this culture, can be understood to some extent by the historical role of shame in community-building and maintenance (elaborated on in the next section). However, it is clear that in the long-term, this culture of shame and cover-up surrounding CSA and other 'undesirable' phenomena (such as pregnancy outside of marriage), warped by the disproportionate power that the Church wielded only served to destroy communities across generations, in addition to the individual lives directly affected.

The Cloyne Report of 2011 was an investigation of clerical abuse in the Diocese of Cloyne from 1996 onwards, and a direct result of the findings elucidated in the Murphy Report (both reports were chaired by Judge Yvonne Murphy). The basis of this report was to see how child protection policies put in place by the Church in 1996 may or may not have had an effect on the culture of reporting and addressing clerical CSA (Murphy et al., 2011).

It was found that the Church's new standards regarding child protection were of a high standard at face value, though those established by the State were 'less precise and more difficult to implement' (Murphy et al., 2011, p. 4). Despite these high standards, 'the guidelines set out in that document [*Child Sexual Abuse: Framework for a Church Response*] were not fully or consistently implemented in the Diocese of Cloyne in the period 1996 to 2009' (Murphy et al.,

2011, p. 5); reporting requirements were not always followed by clergy members, some of whom did not agree with reporting allegations of abuse to civil authorities. Furthermore, the Vatican itself objected to many of the points of the framework, making it clear that the document 'not an official document of the Episcopal Conference', and that the mandated reporting requirement in particular 'gives rise to serious reservations of both a moral and a canonical nature' (Murphy et al., 2011, p. 5). This response consequently signalled to clergy members that implementation of the framework was a matter of opinion that could be left to the discretion of individuals, rather than an urgent necessity that should have been implemented with immediacy and standardisation.

Like the Ferns and Murphy reports, the Cloyne report exposed a systemic disinterest in the protection of children from sexual abuse and a culture of placing the interests of the Church above all else. Between 1996 and 2009, 19 clerics in the diocese were accused of CSA, with only some of these allegations being reported to the Gardaí. One conviction was ultimately made. The disengagement of the Bishop of the diocese at the time (Bishop Magee) from matters of CSA has been cited as the main reason for the continued prevalence of CSA allegations in the region; the unwillingness of clergy members working under the Bishop to follow the rules set out in the child protection framework was a secondary, yet equally damaging reason for the continuation of the abuse.

1.2.2 Current Prevalence of CSA in Ireland

The exposure of clerical abuse has spurred immense cultural changes in Ireland, reflected to some extent by the reforms of child protection law in the past 20-30 years. Nevertheless, efforts to curb CSA, and remove barriers to the discovery of CSA within institutions and family units must continue. As of 2022, the Central Statistics Office (Central Statistics Office, 2023) reported that 29% of adults had reported experiencing sexual abuse as a child (with the true rate almost certainly being higher), with girls experiencing three times the level of CSA as boys. The majority of respondents who had experienced CSA reported that their perpetrators had also been minors.

Reflecting trends in social media and phone usage, 33% of cases of CSA in people aged 18-24 were of non-contact abuse (e.g. being shown pornography non-consensually, being made to create/send sexual images, etc.). Rates of reported CSA were, predictably, higher in younger generations. The prevalence of CSA in Ireland did not see a meaningful decrease in 2022, and has generally stayed the same—therefore, research into ways in which CSA-related mental health outcomes continues to affect lives, and investigating how some of these outcomes, namely shame, can be prevented, remains paramount.

1.3 Shame: Overview, Relevance to CSA, and Therapeutic Approaches

Based on the research into the experiences of CSA survivors worldwide, and on the historical background of Ireland when it comes to the context of Catholicism, institutional abuse, and their cultural impact, it is clear that shame plays a central role in shaping the trajectories of those affected by CSA. But first, in order to understand the nuances of shame in circumstances of trauma, it is necessary to explore the speculated origins of shame, and its suggested utility in non-traumatic (typical) contexts.

While most people can attest to knowing what it is like to feel shame (or feel ashamed), it is an emotion whose definition is very context- (and often individual-) dependent. Commonly, it is defined as a ‘self-conscious’ emotion, in the same family as guilt, embarrassment, pride, and self-blame, among others (guilt and self-blame are described in more detail in Chapter 3; Stearns, 2017; Tangney, 1998; Tangney et al., 2007). The central trait of the self-conscious emotions, as the name suggests, is *“the capacity to evaluate self in light of others”* (Stearns, 2017, Exploring shame, para. 5). As there is some degree of learning involved in the development of these kinds of emotions, children only begin to display them in early toddlerhood. This is a very relevant trait in the context of CSA, as it means that the development of CSA-related shame can be influenced one way or another if intervention begins at a very early stage.

Shame generally emerges as a response to a (perceived) violation of group norms or morals, and (unlike guilt), implicates the individual's core self, rather than a specific action they have done, in the commission of this violation. As a result, the individual who has committed the violation is expected to repent for it by having their sense of self 'punished' (or punishing it themselves) via self-abasement. This can take the form of being ostracised or exiled from one's community for a period of time, or acts of hiding, such as self-imposed avoidance of social settings, or avoidance of eye-contact (Stearns, 2017). Whatever the specific act of punishment, the goal of shaming someone is to cause prolonged psychic pain to make the individual realise the gravity of their norm violation. Indeed, a study of perceptions of shame and guilt within a Chinese context seems to demonstrate that between shame and guilt, forms of shame are much longer-lasting (Bedford, 2004; Gilbert & Irons, 2008).

Another crucial characteristic of shame, is that it must be enforced by group/societal norms (Stearns, 2017). While on one level this means community members themselves will determine whether someone has violated group norms (and then decide what their shaming punishment should be; i.e. public shaming), as shame becomes more ingrained in a community and thereby abstracted, community members internalise the role of the shamer, and can begin to police and punish themselves by shaming themselves (similar to a panopticon leading to internalised authority and self-surveillance). This facet of shame is key to understanding how CSA-related shame can be tackled on a societal level.

While it is not clear when it first evolved as an emotion, shame is understood to be uniquely powerful at maintaining social norms, sometimes at the cost of individual members of the community (Jacquet, 2015; Stearns, 2017). It acts as a (self-) regulatory mechanism, as the intense emotional and mental suffering cause by shame can be an effective deterrent to conducting oneself in ways that violate societal standards. Communities may have different triggers for shame as well as different ways of expressing or managing it, once again highlighting how context-dependent the definition and functioning of shame can be. For instance, in some

cultures shame might be more closely tied to family and community (Chapter 3 discusses family honour in detail) whereas in others, it might have more to do with personal achievements or failures.

Moreover, while in modern Western societies, shame is commonly talked about as an undesirable feeling that people should largely be free of, in her book *Is Shame Necessary*, researcher Jennifer Jacquet argues that we may have gone too far in ridding ourselves of shame, and that it might actually be necessary to enact change around issues such as climate change and income inequality; nonviolent forms of public shaming may be a useful tool against people in power, for example (Jacquet, 2015). However, it is also important to keep in mind that shame is not an inevitable development in the course of humanity, as some cultures throughout history do not seem to have utilised shame in their social dealings (Stearns, 2017)—this finding indicates that there is opportunity to explore social cohesion tools that may be less destructive than shame, something that would immensely benefit survivors of abuse.

1.3.1 Shame in the Context of CSA

Unlike many who experience shame in the general sense outlined above survivors of CSA seem to internalise the shame resulting from their abuse at a much deeper level, often treating it like a core part of their identity throughout their lives (DeYoung, 2015; Sanderson, 2006). Rather than accepting that they were the victims of abuse, survivors often attribute the abuse to their own lack of worth, or some other perceived ‘defect’ the abuser saw in them—this subsequently leads to the belief that they deserved the abuse. As shame requires an audience (literal or internalised) to exist, it is very often the case that the shame of CSA survivors persists in the long-term due to how they are treated by community members and the wider environment. Cultural attitudes around sex and abuse often tend to stigmatise the victims of sexual abuse, sometimes due to the discomfort that people may feel about their ability to deal with these topics (and, perhaps inadvertently, blaming the survivor for ‘burdening’ them with the emotional responsibility of dealing with a disclosure of abuse).

Left unaddressed, CSA-related shame can and most often does impact every aspect of a survivor's life. It is associated with several psychosocial problems such as low self-esteem, anxiety, depression, and difficulties in forming healthy relationships, as will be discussed in detail in Chapter 3. In addition, in order to avoid the feeling of shame, survivors may engage in behaviours that are ultimately harmful to them as a coping mechanism. (Aakvaag et al., 2019; Milligan & Andrews, 2005; Pantelic et al., 2017; Sanderson, 2006). The all-encompassing nature of shame, and the hiding behaviours that it encourages in survivors, can further interfere with the healing process by inhibiting survivors from disclosing the abuse or otherwise seeking help.

Hence, a central aspect of improving the long-term quality of life of survivors is addressing this shame, preventing it, and mitigating it. This is equally important in both therapeutic contexts as well as in wider society; this study will examine both in an attempt to understand the nuances of the mechanisms of shame in the Irish context, and to enable additional research into the development of more effective social and clinical interventions to address CSA-related shame.

1.4 Thesis Objectives and Methodologies

The first aim of this thesis is to gain a comprehensive understanding of the shame in the specific context of CSA . This is done through a formal, pre-registered systematic review, exploring both quantitative and qualitative studies (Chapter 2). This piece of work aimed to address some of the specific recommendations of a recent scoping review of this area performed by MacGinley et al. (2019).

The second aim of this thesis was to explore relations between shame in survivors of CSA and mental health outcomes (Chapter 3). The choice of variables and the models to be tested were informed by the results of the systematic review. As part of this work, the appropriateness of existing measures of shame for use with CSA survivors, as well as the practicalities and logistics of performing such research, were explored. An additional aim was to undertake this work with a population including migrant women

The third aim of this thesis was to gain a deeper understanding of the experience of shame in adult survivors of CSA by using qualitative methodologies. This was done by interviewing both survivors themselves, as well as professionals working in this area, in order to explore what areas of their accounts triangulated and which did not (Chapter 4).

The final aim of this thesis was to attempt to synthesise lessons learned from the systematic review (Chapter 2), quantitative analyses (Chapter 3) and qualitative research (Chapter 4), and to point to areas that future research should aim to explore.

Note on Terminology (Victim vs. Survivor; Child Sexual Abuse Materials vs. Child Pornography)

The word ‘survivor’ is used in the majority of this thesis to refer to people who have experienced CSA, rather than ‘victim’. This choice is based on a bed of research on trauma-informed terminology, which includes perspectives of sexual abuse survivors and people from other marginalised populations, who have expressed that the term ‘survivor’ is more empowering to them, especially when referring to adults who experienced child abuse. While the term ‘victim’ might be appropriate when directly discussing the act/crime of the abuse or referring to the survivor in the immediate aftermath of the abuse, overall it diminishes the wholeness of the person, and fails to highlight their resilience and strength (Jordan, 2013; Julich et al., 2020; Williamson & Serna, 2018). However, it must be recognised that the term ‘survivor’ also has its drawbacks, such as the implication that survivors have made it to the ‘other side’ of their abuse experience, when in reality healing from CSA is a lifelong process.

Similarly, in Chapter 4 the thesis refers to child sexual abuse material (CSAM; images or other media depicting a child being sexually abused). Popular culture often calls this ‘child pornography’; however this is seen by survivors and CSA researchers alike as an extremely inappropriate term as it diminishes the harm of CSAM, and implies that (due to the legality of adult pornography in many places and its widespread use as a form of entertainment), there is a

category of CSAM that is acceptable or not harmful (Australian Centre to Counter Child Exploitation, n.d.; NSPCC, 2023). Therefore, CSAM is used in this thesis.

Chapter 2: Experiences, Causes, and Consequences of Shame in Childhood Sexual Abuse

Survivors: A Systematic Review and Narrative Synthesis

2.1 Introduction

2.1.1 *Diverse Effects of CSA*

As detailed in Chapter 1, the effects of CSA are wide-ranging and interrelated, ultimately impacting multiple spheres of survivors' lives. Recent systematic reviews have established CSA as a risk factor for several negative conditions including psychopathology, sexual dysfunction, problems with social interaction, and a range of physical health problems (MacGinley et al., 2019; Maniglio, 2009; Saraiya & Lopez-Castro, 2016). While there is variation in the extent to which CSA influences these outcomes, much of the evidence suggests that the wounds inflicted by CSA can be apparent and immediate, but also insidious and indirect or latent, affecting people via complex and as yet insufficiently understood mechanisms.

2.1.2 *Somatic and Biological Effects of CSA*

The physical sequelae of CSA are well documented. Some common medical and somatic effects of CSA include increased rates of: adverse general lifetime health, gynaecological and pulmonary problems, chronic pelvic as well as general pain, gastrointestinal problems, and obesity (Irish et al., 2010; Paras et al., 2009). A narrative literature review by Wilson (2010) points to a trend of CSA survivors accumulating more doctor's visits over their lifetimes than those without CSA experiences, and other studies indicate that survivors report more medical complaints (muscle pains, headaches and migraines, etc.) and seek less perinatal care than non-abused individuals (Leeners et al., 2006; Newman et al., 2000).

Another line of research in this field focuses on the links between CSA and subsequent neurological or biological functioning. A prospective controlled study found that CSA seems to be associated with increased sensitivity of the hypothalamic-pituitary-adrenal response (a major factor in the autonomic stress response) in women exhibiting symptoms of depression and anxiety

in adulthood, thereby prolonging survivors' struggles (Heim et al., 2000). Furthermore, in a 2016 study that examined multiple parameters of the immune system, adolescents with a sexual abuse history were shown to have significantly 'dysregulated' immune systems (which is consequently linked to autoimmune disorders) compared to their non-abused counterparts. This finding is supported by other studies on the biological sequelae of childhood adversity (Ayaydin et al., 2016; Berens et al., 2017).

2.1.3 *Psychosocial and Mental Health Effects of CSA*

The association between CSA and negative psychosocial and mental health effects is arguably even better established than CSA's physical effects. Maniglio's (2009) systematic review of reviews concluded that adults with CSA histories are significantly more at risk than non-abused adults of "psychotic symptomatology, depression, anxiety[...], dissociation, eating disorders[...], personality disorders (especially borderline personality disorder), self-esteem and self-concept impairment, suicidal and self-injurious ideation or behavior, substance abuse, sexual dysfunction, engagement in high-risk sexual behaviors," (p. 654) and several other problems. Depression, suicidality, and post-traumatic stress disorder (PTSD) are well-documented to be highly likely acute and chronic mental health outcomes of CSA; depression has in some studies even been shown to moderate the relationship between CSA and adult health problems (Collin-Vézina et al., 2013; Dube et al., 2005; Newman et al., 2000).

Although not researched to the same extent as the previously mentioned outcomes, shame has also appeared as a prominent theme in the lives of CSA survivors (Alaggia et al., 2019; Collin-Vézina et al., 2015; McElvaney et al., 2014). The mechanisms by which shame operates and affects survivors' mental and physical health has not been very widely investigated, but it does seem to have strong associations with PTSD, which further highlights the significant role shame has in the development and/or maintenance of health and social issues (Saraiya & Lopez-Castro, 2016).

2.1.4 The Significance of Shame

2.1.4.1 What is Shame?

As described in Chapter 1, shame is generally conceptualised as a self-conscious emotion characterised by a negative evaluation of the global self as a result of events or behaviours that are perceived to violate moral norms of the society in which one lives (Tangney, 1998). It is an emotion that negatively characterises oneself, puts down one's behaviours and inherent traits, and "involves painful self-scrutiny and self-condemnation, along with feelings of worthlessness and powerlessness." (Øktedalen et al., 2014; Tangney et al., 2007). The perception of oneself as inherently flawed or damaged may be a result of internalised cognitions of unworthiness developed over time, or of current, in-the-moment, external signals from one's community after a particular event or behaviour. Regardless of the source, shame is ultimately a deeply personal and subjective experience.

2.1.4.2 Shame vs. Guilt.

Within the discourse of self-conscious emotions, the distinction between shame and guilt is an important one. In everyday language, the terms 'shame' and 'guilt' are often used synonymously. However, they fundamentally differ. While shame directs negative feelings internally, toward one's self, feelings of guilt are usually detached from negative self-evaluations and instead focus on negative evaluations of the behaviour(s) that led to feeling shame (Tangney, 1998). So in relation to the same negative event, a person feeling shame would say "I'm a bad person, I'm dirty, I'm tainted, I'm dishonest, etc.," but a person feeling guilt would say "What I did was wrong, what I did was dishonest, what I did was unhygienic, etc." Tangney et al. (2007) also theorises that shame is associated with a person's preoccupations about how others judge them, while feelings of guilt lead to concern about how one's behaviour has affected others. One final distinction between shame and guilt relates to the consequent actions in which each emotion results. Shame often leads to avoidant, self-hiding or self-destructive behaviours, while guilt often

leads to reparative or restorative behaviours that aim to protect the relationships of the people involved in the precipitating event (Tangney, 1998).

2.1.4.3 *Mild Shame vs. Extreme Shame.*

Experiencing shame is to some extent a normal and healthy part of life, especially in childhood. Shame is often used to discourage socially undesirable behaviours in children (such as behaviours that compromise their hygiene). This kind of adaptive shame can be considered 'mild shame'. Although mild shame may be thought of as relatively harmless (which in itself is debatable), it can become maladaptive when it turns into what is known as 'extreme', 'traumatic', or 'pathological' shame in situations where a person has gone through trauma or damaging events that were no fault of their own (Herman, 2011). This maladaptive type of shame is what is most relevant to CSA experiences, and is the focus of this review.

2.1.5 *Shame in the Context of CSA*

Many studies have already shown that extreme shame, a common consequence of CSA, is associated with more intense PTSD symptoms and deleterious physiological and social outcomes. Having synthesised the results of many of these studies, a robust scoping review on shame and PTSD found that for a range of traumas including CSA, shame was associated with "greater negative and self-critical thinking, hyperarousal, avoidance, intrusive recollections, bodily shame, and negative attributions of the traumatic occurrence" (Saraiya & Lopez-Castro, 2016, p. 10) as well as with "increasing sympathetic nervous system activity" and "complex PTSD symptoms" (Saraiya & Lopez-Castro, 2016, p. 10). Studies have also highlighted the mediating role of shame in the development of PTSD and other disorders after multiple kinds of traumas, and its role in preventing the disclosure of CSA, potentially due to the fear of being publicly shamed and shunned from their communities (Alaggia et al., 2019; Collin-Vézina et al., 2015; MacGinley et al., 2019; McElvaney et al., 2014; Paine & Hansen, 2002). However, as Saraiya and Lopez-Castro (2016)

stress, there is little research into the therapeutic outcomes of addressing shame in clinical populations, particularly in adult populations of CSA survivors.

2.1.6 Objectives of this Review

MacGinley et al.'s (2019) scoping review on shame and CSA concluded that CSA-related shame is an under-researched area requiring higher quality studies, particularly studies about clinical interventions to combat shame. The paper ends by calling for a full systematic review on shame and CSA; this current review may be viewed as a response to that call. The following are the questions this review attempts to answer:

1. What is known about experiences of shame in CSA survivors, both in terms of prevalence and phenomenology?
2. What factors seem to promote or mitigate experiences of shame in CSA survivors (including preventative factors and coping strategies)?
3. What are the potential cognitive, affective, social, physical, and mental health consequences of shame in CSA survivors?

Additional objectives of the review include:

4. Synthesising existing data on shame/self-blame to better illustrate the complex way in which shame affects survivors.
5. Identifying suitable focal points for clinical intervention research

Finally, the current study builds on the MacGinley et al. (2019) review in the following ways, enriching the collective data and conclusions arising from research in this area:

1. Two independent reviewers participated in the screening and selection process (SAV and SMJ)
2. There is a focus on the conceptual overlap between shame and self-blame.

3. There is an increased analytical focus on quantitative studies.
4. There is a higher number of qualitative studies included in this review.

2.2 Methods

2.2.1 *Preregistration, Database Selection, and Search Strategy Construction*

In accordance with best practice guidelines for open science (Center for Open Science contributing authors, n.d.; Nosek, et al., 2018), a protocol for this review was first developed and pre-registered with PROSPERO, a systematic review database (Vembar, et al., 2019). The protocol contains the review's methods and main research questions, among other information. The full protocol can be accessed here: https://www.crd.york.ac.uk/prospero/display_record.php?RecordID=134818.

The databases Web of Science (Core Collection) and PubMed were selected for this study due to the large volume of journal articles they contain, their inclusion of articles from several other databases (such as MEDLINE, which PubMed encompasses), and the lower probability of overlap of articles between them (Falagas et al., 2008; García-Pérez, 2011).

Search strings were used in each database to find articles that investigated both CSA and shame. The two search strings utilised the same search terms, and only differed in the way each database's boolean search operators were required to be formatted within the strings. The search terms used in the strings were derived from the concepts 'child sexual abuse' and 'shame'; along with those terms themselves, a list of other closely related terms, and words (and their variations), were brainstormed and tested on the databases before being added to the string. In particular, synonyms and words commonly interchangeable with CSA and shame (such as 'child sexual exploitation' and 'embarrassment') were used. In addition to the free-text words and phrases in the search strings, Medical Subject Headings (MeSH) terms for 'child sexual abuse', 'shame', 'guilt', and 'social stigma' were included in the search string on PubMed. As an example, the following is the search string that was used in PubMed:

(((("guilt"[Mesh]) OR "shame"[Mesh]) OR "Social Stigma"[Mesh] OR "ashamed" OR "sham- ing" OR "shameful" OR "social stigma" OR "guilt" OR "guilty" OR "stigma" OR "stigmas" OR "stigmatized" OR "stigmatization" OR "stigmatizing" OR "self-blame" OR "self blame" OR "disgust" OR "disgusted" OR "prejudice" OR "prejudiced" OR "prejudicial" OR "hu- miliate" OR "humiliating" OR "humiliated" OR "humiliation" OR "disgraced" OR "disgrace" OR "embarrassment" OR "embarrassing" OR "embarrassed")) AND (((("Child Abuse, Sex- ual"[Mesh]) OR ("child sexual abuse" OR "childhood sexual abuse" OR "child sex abuse" OR "childhood sex abuse" OR "child maltreatment" OR "child mistreatment" OR "child sex- ual maltreatment" OR "childhood sexual maltreatment" OR "child sexual assault" OR "child- hood sexual assault" OR "child molestation" OR "childhood molestation" OR "sexual child molestation" OR "child molestation, sexual" OR "child sexual molestation" OR "child sexual harassment" OR "childhood sexual harassment" OR "CSA" OR "child mistreatment, sex- ual" OR "childhood mistreatment, sexual" OR "sexual abuse, minor" OR "teenage sexual abuse" OR "teenage sex abuse" OR "teen sexual abuse" OR "teen sex abuse" OR "ado- lescent sexual abuse" OR "adolescent sex abuse" OR "sexual abuse, adolescent" OR "sex abuse, juvenile" OR "sexual abuse, juvenile" OR "underage sex abuse" OR "underage sex- ual abuse" OR "non-consensual, child" OR "non consensual, child" OR "non-consensual touch, child" OR "non consensual touch, child" OR "forced sex, child" OR "forced inter- course, child" OR "child sexual exploitation" OR "child sex exploitation " OR "child rape" OR "childhood rape" OR "statutory rape" OR "child grooming " OR "childhood grooming" OR "sexual enslavement, child" OR "sex trafficking, child" OR "sex trafficking, childhood" OR "sex trafficking, minor " OR "sexual coercion, child" OR "childhood sexual coercion")))))

Searches were conducted in both databases on May 30th, 2019. There was no lower limit for the date of publication. Once both databases were searched, reference data (including abstracts) of all returned results were transferred to EndNote (version X9), where the results were automatically assessed to remove duplicates. Once duplicates were removed by EndNote, the references were uploaded onto Covidence, a cloud-based systematic review management software, where further duplicates were automatically removed (Covidence Systematic Review Software, 2020).

2.2.2 Inclusion and Exclusion Criteria

Studies needed to fulfil a set of demographic as well as design- and analysis-related criteria to be included in the final review. In terms of demographic criteria, studies could include participants of any age and gender who had experienced CSA (i.e. sexual abuse before the age of 18 years). Participants could be of any race, nationality, ethnicity, and socioeconomic status. Studies were excluded if none of the participants had experienced CSA, and also if they had only experienced sexual abuse after turning 18 years old.

In terms of design- and analysis-related criteria, study design could be qualitative or quantitative. Studies also had to: involve empirical research where some sort of first-hand data were collected, be published in peer-reviewed journals (or be grey literature in the form of masters' or doctoral theses), and have their full text available in either English or Spanish. Studies had to have investigated CSA as a major or the main component of the study, AND had to significantly feature analysis or discussion of shame (or a closely related concept such as self-blame). This meant that in qualitative studies, shame had to have been a topic of inquiry or discussed as a theme in the results, and in quantitative studies, shame had to have been explicitly analysed as a variable. Studies that did not meet all of these criteria (e.g. literature/other systematic reviews and meta-analyses that by definition do not collect first-hand data), were excluded. While studies that investigated adult sexual abuse along with CSA were considered, studies that only investigated adult sexual abuse were excluded. Additionally, studies on concepts such as 'child maltreatment', 'adverse childhood experiences' and 'sexual abuse history' whose results did not clearly distinguish CSA from other types of childhood abuse (or CSA from adult sexual abuse, ASA) were excluded.

2.2.3 Study Screening and Selection Protocol

Two researchers (SAV and SMJ) independently screened articles at the title and abstract phase. At the end of this phase, SAV and SMJ met to discuss and resolve voting conflicts. Arguments for and against including certain articles were discussed in depth over the course of several meetings.

Once all the articles for the full-text screening phase were selected, SV sourced the texts for the majority of the articles and uploaded the documents onto Covidence. Where article texts were unable to be found or accessed, EN and SMJ were consulted to find alternative sources. Once all possible texts were uploaded, SAV and SMJ independently screened the articles at full-text level. As with the abstract phase, voting conflicts were discussed at length and a consensus was reached regarding articles to be included in the final review. Any duplicates encountered during the screening phases were manually removed. Figure 2.1 (a PRISMA flowchart) below outlines in detail the screening process (Liberati et al., 2009).

2.2.4 Study Text Acquisition

For studies that entered the full-text screening phase, full texts were obtained exclusively online, via traditional academic databases, Google Scholar, and Sci-Hub. Out of the 474 studies sent to the full-text review stage, 16 were inaccessible online. Efforts were made to locate these articles' physical copies in university libraries, but due to the COVID-19 lockdown they were unable to be accessed in time and were therefore excluded.

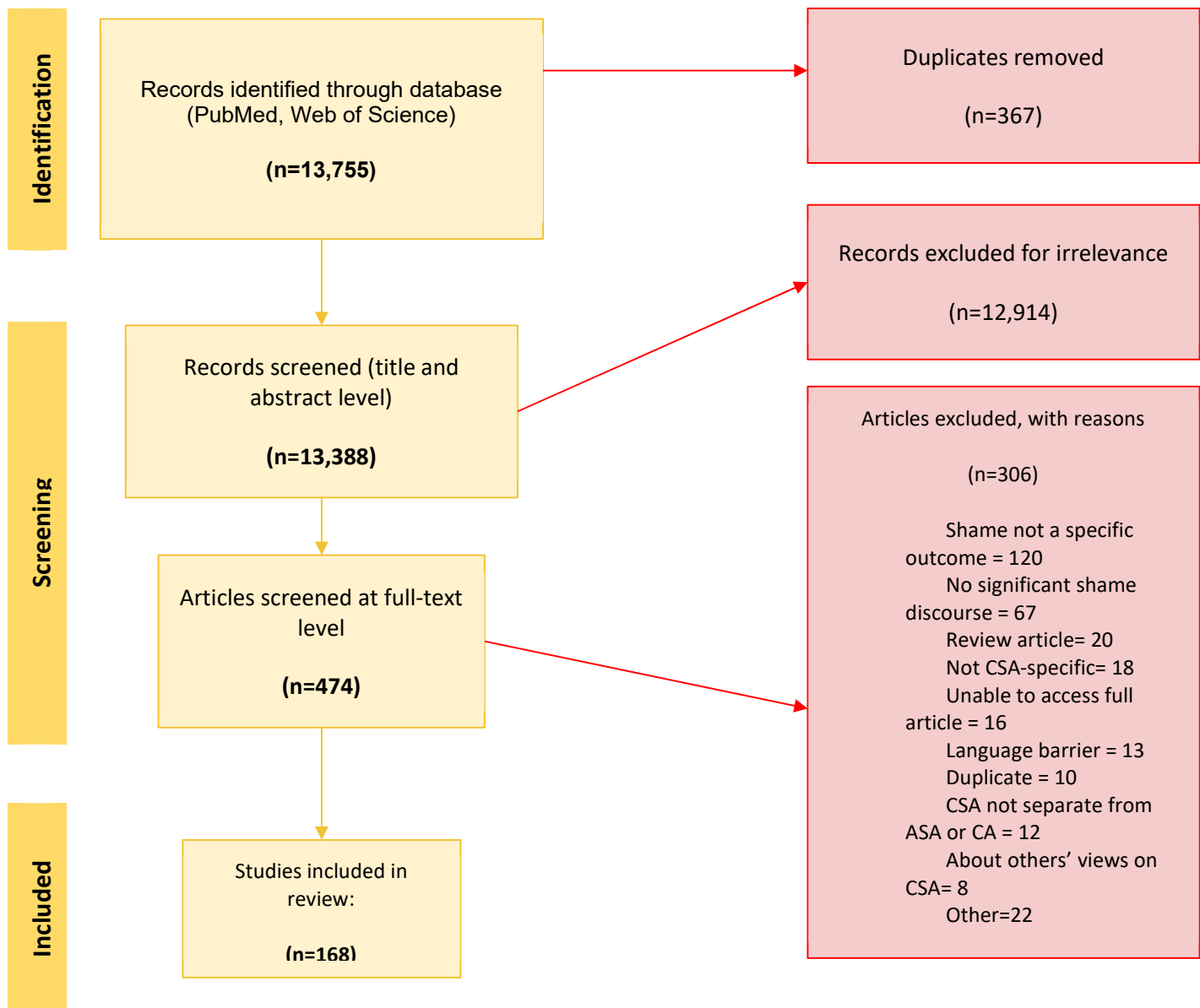


Figure 2.1

Standard PRISMA flow chart detailing the screening and selection process.

Data extraction was conducted by SAV and SMJ, initially on Covidence and then on an Excel spreadsheet. Major components and outcomes of the studies were extracted, and then further analysis such as thematic analysis was performed. The following outcomes were extracted from the final studies: reference information, descriptive information (design and methodological details, sample characteristics, data collection timeline, measure(s) of shame used if applicable), and the main findings of each study.

2.2.5 Analysis Method

Analysis of the data was carried out using the narrative synthesis method developed by Popay et al. (2006). Narrative synthesis was used as the studies in this review lack the methodological homogeneity for the more specific or quantitative analysis for a meta-analysis. Popay et al.'s model begins with theory development around shame and CSA, after which a preliminary synthesis of initial data is conducted (e.g. tabulation, sample characteristics, etc.). Then relationships between and within studies were analysed; the model lists two types of relationships of particular interest: that between studies' characteristics and their findings, and that between the results of different studies. The final step in the analysis was evaluation of the strength of the relationships that emerge in the secondary analysis.

2.3 Results

The data extraction tables from which the results below are drawn can be found at this link for reference:

<https://docs.google.com/spreadsheets/d/1UP8ulmDcAD75QL6Yk47TZDxnBug4ywfutGiSzi6dth4/edit?usp=sharing>

Given the heterogeneity of the included studies, while general descriptive information for the studies is provided in the first section below, further results have been split into quantitative, qualitative, and mixed-methods categories. Each category contains descriptive information in written and tabular form, and a synthesis of the main themes and relationships that have emerged based on the thematic analysis of the studies.

2.3.1 Study Designs and Samples

Out of the 168 studies selected for final analysis, 81 were quantitative, 81 were qualitative, and six were mixed-methods studies. This resulted in an even split between quantitative and qualitative studies dealing with shame in a CSA context. Of all included studies, 91.6% were conducted in WEIRD (Western, Educated, Industrialised, Rich, Democratic, Heinrich et al., 2010) countries. Within the quantitative group, 79 of the 81 studies were conducted in WEIRD countries (and five studies conducted in WEIRD countries studied marginalised populations within them). Sixty-nine of the 81 qualitative studies were conducted in WEIRD countries, and all of the six mixed-methods studies were conducted in WEIRD countries. Of all included studies, 11.9% (20 out of 168) had samples where male participants made up 50% or more of the sample; seven studies did not report the gender breakdown of their samples. Out of 168 studies, only 89 reported the mean age of their samples; based on these 89 studies, the mean age of the collective sample is 30.6 years. Forty-four studies only reported the age range of the samples, and 24 studies did not report any age statistics. The mean age of participants in quantitative studies (27.4 years) was lower than that of qualitative studies (33.7 years).

2.3.2 Assessment/Validation of CSA History

Three ways of assessing participants' CSA histories were utilised across the studies included. The most common was self-reporting of CSA history (58 quantitative and 81 qualitative studies). Identification via clinical services was the next most common (it was not elaborated if researchers further investigated how the services' clients were identified). Finally, identification via child protective services or law enforcement personnel was the least common method.

2.3.3 Variations in the Measurement of Shame

While all studies included in this review explicitly mention shame as part of their outcomes or themes, in the context of the quantitative studies the way in which shame was assessed differed

significantly in methodology and content of assessment. Seventeen of the quantitative studies did not involve a shame-specific tool or question to assess shame in participants, or did not report the use of such a tool. While the remaining 66 quantitative studies had dedicated measures of shame (in the form of shame inventories/questionnaires/subscales, or a single question assessing shame specifically), there was a wide variety in the scales and questions that were used. Out of these 66 studies, nine used bespoke (created specifically for the study and not previously validated) scales or questions to assess shame, and 57 used existing, validated scales or subscales of larger questionnaires.

Almost all tools used to assess shame were self-report tools rather than researcher- or clinically-administered ones. However, three studies (Bonanno et al., 2002; Bonanno et al., 2003; Negrao et al., 2005) used a researcher-coded behavioural tool called the (Emotional) Facial Action Coding System (FACS; Ekman & Friesen, 1976), whereby participants' facial movements were analysed to detect shame. FACS was developed in order to distinguish between all visible facial movements, and is widely used as a way to interpret anatomical/muscular changes in expression. The FACS itself does not map specific combinations of facial movements onto specific emotions, and is also limited to clear, muscular movements in the face—this leaves out the ability to include more subtle/ambiguous movements, as well as non-muscular facial reactions such as sweat and temperature, in the interpretation of emotions. Nevertheless, according to one of the only psychometric evaluations of the FACS, it has shown adequate validity and reliability in distinguishing between the groupings of its established facial movements, and is viewed by researchers as a trusted method of measuring emotion (Clark et al., 2020; Sayette et al., 2001).

In terms of self-report measures used in the studies, the shame assessment tools of Feiring (The Abuse-Specific Shame Questionnaire, Feiring et al., 1998, and The Shame Questionnaire, Feiring et al. 2002) were among the more commonly-utilised, appearing in 18 studies (many of which were Feiring's own). This is to some extent expected given the focus of much of Feiring's

research is specifically shame and CSA; while Feiring's scales are specific to CSA-related shame, they are limited to use with minors (and are therefore fairly short in length), and it appears that similar scales have not been created for use in adult populations.

2.3.4 Quantitative Findings

2.3.4.1 Descriptive Information for Quantitative Studies

Half of the studies (81 out of 162, 50%) that were deemed relevant to the topic of CSA and shame were quantitative in design. These studies were mostly cross-sectional, correlational investigations of multiple outcomes related to CSA, of which shame was an outcome. The majority of the studies dealt with adult participants—the mean age of the collective sample was 27.4 years (based on the 53 of 81 studies that reported the mean sample age). As expected, the gender breakdown of the samples skewed drastically towards female participants, with only seven out of 81 (8.6%) studies having samples where 50% or more of the participants were male. The mean sample size was 335, and the total combined sample size of all studies was 26,781.

The vast majority of the quantitative studies on CSA and shame were conducted in WEIRD countries or WEIRD populations within non-WEIRD countries. Only seven out of the 81 quantitative studies were conducted in non-WEIRD countries or populations (Daral et al., 2017; Feiring et al., 2001; Hamilton et al., 2016; Kallstrom-Fuqua et al., 2004; Michalopoulos et al., 2015; Milligan & Andrews, 2005; Watson et al., 2013). However, the population of the study conducted in India (Daral et al., 2017), while nominally 'non-WEIRD' in its geography, may still be considered a WEIRD sample in some ways (educated, rich, urban) given that its participants belong to a relatively well-off area of New Delhi with a literacy rate of nearly 83% (higher than the national average reported in the 2011 Indian census) (Barakat, 2016; Chandramouli, 2011). Conversely, another study was conducted in Australia (Hamilton et al., 2016), a nominally WEIRD region, but within an indigenous Australian population, which, depending on the specific circumstances of the sample, could be

considered a non-WEIRD population due to severe marginalisation (Biddle et al., 2020; Bodkin-Andrews & Carlson, 2016; Clark et al., 2021; Shepherd et al., 2017)—taking that into account, it is worth reflecting on how diverse the sampling of CSA research in general tends to be, as well as how sample categorisation can be made more precise.

2.3.4.2 Thematic Findings for Quantitative Studies

The major theme underlying all quantitative studies was the clear association between the experience of CSA and shame. That is, shame seems to be a consistent socio-emotional consequence of CSA in both WEIRD and non-WEIRD samples. Hamilton et al., (2016) found that 27% of their interactions with CSA survivors elicited shame responses (both implicit and explicit). In an older study (Peters & Range, 1997), though shame was not an explicitly-investigated outcome, results showed that a significant percentage (54-68%) of a clinical population sample of CSA survivors held the following beliefs, which conceptually amount to shame: “I am worthless and bad,” “Anyone who knows what happened to me sexually will not want anything to do with me”, and “The damage is permanent”.

The severity and frequency of CSA was generally positively correlated with the intensity of shame experienced by survivors (DePaul, 2002; Feiring et al., 1998; Karan et al., 2014; Thomson & Jaque, 2018)--with only one study (Kallstrom-Fuqua et al., 2004) contradicting this finding. Notably, one study found a negative correlation between shame and the age of onset of CSA (Ginzburg et al., 2006), an aspect which is further explored in chapter 4 of this thesis.

Both cross-sectional and longitudinal studies that investigated shame as an explicit outcome of their research have shown lasting shame (such as Feiring, 2005) in both male and female survivors, with some of these studies going further to explore the links between shame and other consequences.

Some studies also showed a marked gender difference in levels of post-CSA shame, with girls and women experiencing higher levels of shame than boys and men (e.g., Feiring et al., 1999 & 2002). One of these studies (Feiring et al., 1999) recorded a significant decrease in shame levels in girls, but not boys, over the course of one year.

A small number of studies found no significant overarching relationship between CSA and shame (Alexander, 1991; Dorahy et al., 2016; Feinauer, 2003; Kealy et al., 2017; Kealy et al., 2018; Wiechelt & Sales, 2001). In particular, Feinauer (2003) found that many survivors do not end up internalising their CSA-related shame over the long-term, and are able to create meaningful and intimate relationships in adulthood. Wiechelt and Sales (2001) demonstrated that while the mean shame scores of survivors were higher than those of the general population, they did not meet or exceed the threshold for problematic levels of internalised shame indicated by the scale used (*Internalized Shame Scale*; Cook, 1996). Finally, Dorahy et al. (2016) demonstrated that in a sample of survivors with dissociative disorder, C-PTSD, and other psychiatric disorders, emotional abuse was the only type of childhood abuse to predict shame (and guilt); CSA was not a significant predictor of either in the models used in this study. Given the specificity of these studies (and generally all the studies in this review) with regard to their focal points, sample characteristics, and their measurement tools and analysis techniques, it can be expected that in certain cases the relationship between CSA and shame will not hold. Nevertheless, the overwhelming majority of studies still support a significant relationship between the two.

Generally, in cross-sectional studies the CSA-shame relationship was determined via correlational, regression, group-comparison (ANOVAs, t-tests), or factor analysis of self-report data on CSA experiences and shame. Clinically-administered measures were, comparatively, seldom used due to fewer such tools existing. The additional time and labour costs associated with conducting clinical interviews could also be an explanation for their relative lack of use. The overarching message of these cross-sectional studies is the clear emergence of shame in the

aftermath of CSA. As most of the studies involve survivors who have only been surveyed about their CSA-related shame in adulthood, the apparent long-lasting nature of this shame is revealed as another theme.

Within the cohort of longitudinal studies examined, results were fairly varied given the diversity of the research questions of the studies. Notably, research by Feiring and colleagues dominated the longitudinal set of studies in this review. Two of these studies (Feiring et al., 2000; Feiring & Tasaka, 2005) demonstrate the differing effects of what they term ‘general shame’ and ‘abuse- or CSA-related shame’. Both studies, which sampled children via clinical services, showed an association between general-shame at baseline and reduced satisfaction with support from same-sex friends and less close friendships; the studies also showed that CSA-related shame at baseline was not related to either amount or satisfaction of support from friends at baseline, but was associated with lower feelings of peer-acceptance at baseline. While in these studies, the counselling that the children received did seem to reduce shame overall, it did not affect the aforementioned relationships between CSA-related shame and satisfaction with friendships/ or support from friends.

Longitudinal research is important to the creation of more valid and reliable knowledge, and in the case of tracking the progress of interventions, such as those targeting shame, is necessary. Other longitudinal studies investigated the effects of varying treatment protocols on shame, and generally found that the clinical interventions utilised were effective in reducing shame several months-to-a year post-intervention. Interventions ranged from variations of cognitive behavioural therapy (CBT) and dialectical behavioural therapy (DBT), to group psychotherapy protocols, support groups, and self-aversion therapy. These will be discussed further in the sections below.

2.3.4.2.1 *Association of Shame with Depression, PTSD, and Other Negative Psychological Outcomes*

The MacGinley et al., 2019 scoping review, referred to in the Introduction, identified several studies that found associations between the experience (and persistence) of shame after CSA with negative psychological, social, and behavioural problems in the short- and long-term. The present review echoes and expands on these findings below.

The overwhelming majority of quantitative research on shame and CSA links the experience of shame to adverse psychological outcomes, principally to PTSD and depression (or specific symptoms of these diagnoses). Several studies demonstrated a correlation between shame in child and adult CSA survivors and depression (as well as suicidal ideation specifically), PTSD symptoms (intrusive thoughts, hyper-arousal, avoidance), or both (Alix, 2017; Ellenbogen, 2018; Ginzburg et al., 2006; Feiring, et al., 2002; Kallstrom-Fuqua et al., 2004; Michalopoulos et al., 2015; Neufeld et al., 2012; Persons et al., 2010; Rahm et al., 2013; Simon et al., 2010; Willie et al., 2016). Whilst there were some studies that failed to replicate these findings, (e.g., Ellenbogen 2018, whilst replicating a positive correlation between shame and depression, failed to find a relation between shame and suicidal ideation; You et al., 2012, failed to find a relation between shame and suicidal ideation when using the Hamilton Rating Scale for Depression), these studies were in a significant minority (potential reasons for such disparities are discussed below).

Going further, studies also demonstrated, via a variety of statistical methods such as linear multiple regression, logistic regression, ANOVAs, and Chi-squared analyses, the predictive effect of shame on symptoms of PTSD and depression, and dissociative thoughts, adding to the growing evidence that shame may be an important mediator between CSA and adverse psychological effects (Feiring & Taska, 2005; Feiring et al., 1998a; Feiring et al., 1998b; Kealy et al., 2018; Talbot et al., 1996; Negrao et al., 2005; You et al., 2012).

Studies that utilised methods to assess shame that differed from the typical approach involving self-report questionnaires, also found relations between measures of mental health and shame in CSA survivors. For example, Negrao et al. (2005), investigated the associations between explicit mentions of abuse history, facial shame (as measured by the FACS), verbal indicators of humiliation (a facet of shame), and psychological adjustment (as measured by PTSD symptom levels). Among participants who did not mention their CSA histories during the study, the following was found: 1) when both verbal humiliation and facial shame were present in their responses, more PTSD symptoms were seen, and 2) when facial shame was present but verbal humiliation was not, fewer PTSD symptoms were noted. The authors suggest that ‘emotional coherence’ (when verbal humiliation and facial shame are both present in responses) may be a helpful coping mechanism for those who choose to disclose their CSA, but is in fact not adaptive for those who choose to *not* talk about their abuse; in these individuals, the presence of both verbal and facial signs of shame may instead signal high emotional reactivity, a characteristic of PTSD.

Another study, focusing on the shame-depression link (You et al., 2012) concluded that while higher levels of shame were associated with higher levels of suicidal ideation when measured by the Beck Depression Inventory (BDI; Beck et al., 1996); this association did not hold when suicidal ideation was measured via the Hamilton Rating Scale for Depression (HAM-D; Hamilton, 1960) in adjusted models that accounted for sociodemographic variables, depression and PTSD symptoms, and suicide attempt history (the association still held in the unadjusted models). The authors indicated an uncertainty about what might underpin this discrepancy in the shame-depression link between the BDI and the HAM-D, but that the differences between the tools may have had a non-negligible effect on the analyses, resulting in this finding.

The two scales were used in the study to elevate its robustness, as they differ significantly: the BDI is a self-report scale while the HAM-D is clinician-administered, and the HAM-D focuses more on somatic symptoms of depression than the BDI does. Though the BDI and HAM-D have historically been highly correlated, only recently have efforts been made to actually translate their scores to and from each other (Furukawa et al., 2019)—a pattern that permeates the field of measurement science in psychology. This also raises larger concerns about the standardisation (or lack thereof) of psychological scales (particularly when the methods of administration differ), and how the results of the other studies in this review may have changed in significance levels if alternative tools were used for the measured concepts.

The pathway from CSA-to-shame-to-adverse psychological outcomes was further investigated by two studies that found evidence for a mediating effect of shame in this pathway (Feiring et al., 1998a; Ginzburg et al., 2009). However, other studies looking at this mediational relationship did not arrive at the same results (Kealy et al., 2017; Wolfe-Clark et al., 2017). For example, Kealy et al., 2017 failed to show a significant mediating effect of shame in the relationship between CSA and somatic symptoms, though a significant direct effect between CSA and somatic symptoms was found when shame and guilt were in the regression model—this may indicate that shame is mediating the link between CSA and psychological symptoms, but not somatic ones. Hence, it appears that a better understanding of the mediators of the relation between CSA and mental health is needed (see Chapter 3).

An important aspect to note about the studies utilising linear multiple regression is the inconsistency in the reporting of results. No studies report full regression tables with R-squared values, adjusted R-squared, and/or predicted R-squared values, instead, some report tables with incomplete effect size statistics (Feiring et al., 1998a; Feiring et al., 1998b; Kealy et al., 2017; Kealy et al., 2018; Ginzburg et al., 2009), while others do not report proper regression tables/effect sizes at all (Talbot et al., 2004). Adjusted and predicted R-squared are crucial statistics to report for multiple regressions; R-squared values usually increase when more variables are added to the model, generally displaying an inflated effect size than what the model actually provides. Adjusted and predicted R-squared values therefore account for 1) the presence of multiple predictor variables in the model and 2) the predictive accuracy of *each* predictor variable, rather than the combined predictive power of all included predictor variables. Effect size measures are also not reported in studies using other analysis methods such as ANOVAs and Chi-square analyses (Feiring & Taska, 2005; Negrao et al., 2005), pointing to an overall limitation in the quantitative studies of this review.

This is not to say the authors of the studies did not attempt to be thorough in their findings. Until recent years it was standard practice to report, for example, only the R-squared values for each regression model that is run; this is also the extent of what was taught in most university-level statistics courses. Considering many of the studies in this section were conducted in the 1990s and early 2000s, the incompleteness of some results sections and the general absence of more accurate effect sizes can be expected. However, with the increasing emphasis in psychology on alleviating the replication crisis and designing more robust methodologies, calculating and reporting effect sizes (and conducting *a priori* power analyses) is fast becoming a requirement for quantitative social science research (Kang, 2021).

In addition to the above results, shame was found to be significantly associated with: general shame proneness (Feiring & Taska, 2005) and internalised shame (Fowke et al., 2012), low self-esteem (Feiring et al., 1998), greater self-consciousness (Gamble et al., 2006), low perceived levels of social support (Persons et al., 2010), and sexual problems (Feiring et al., 1998; Ginzburg et al., 2006; and Simon et al., 2010). Two studies (Neufeld et al., 2012; Persons et al., 2010) demonstrate a positive correlation between CSA-related shame and HIV-related shame/stress in survivors with an HIV diagnosis—this finding seems to highlight the deep-rooted, fundamental nature of shame, as well as its ‘bodily’ components, as discussed below.

2.3.4.2.2 *Association of Shame with Negative Social and Behavioural Outcomes*

Several studies have linked shame to negative social and behavioural outcomes in the short and long term (Cohen, 1995; Feinauer et al., 2003; Feiring & Taska, 2005; Feiring et al., 2013; Feiring et al., 2000, 2009; Feiring & Cleland, 2007; Feiring et al., 1998; Ginzburg et al., 2006; Kallstrom-Fuqua et al., 2004; Kessler & Bieschke, 1999; Kim et al., 2009; Michalopoulos et al., 2015; Neufeld et al., 2012; Persons et al., 2010; Willie et al., 2016; Wilson & Wilson, 2008).

Shame appeared to impair both communication in general, as well as intimacy. Cohen (1995) found shame to hinder effective communication between parents and their children, indicating that the emotional burden of shame can act as a barrier to sensitive discussion. Feinauer (2003) draws attention to the detrimental effects of internalised shame, revealing a negative correlation between shame, and both hardness and intimacy. This suggests that CSA survivors who internalise their shame might struggle to build resilience and form intimate relationships.

Feiring et al. (2013) sheds light on the relationship between stigmatisation and CSA survivors' dating aggression. Stigmatization, which can be linked to shame, is shown to lead to dating aggression through the mediation of anger. However, an earlier study by the same lead author (Feiring et al. 2009) challenges these findings, demonstrating that while post-CSA

stigmatisation predicts sexual difficulties at a 6-year follow-up, it does not predict dating aggression at the same interval. In a third study on the topic, Feiring et al. (2007) found that post-CSA stigmatisation predicts delinquency at a 6-year follow-up, with anger and peer-deviance serving as mediators. Furthermore, Kim et al., (2009) found that shame fully mediated the relationship between CSA and self-verbal aggression – from these studies insight emerges into the cascading impact of shame, starting from stigmatisation and leading to potentially long-lasting behavioural and social outcomes .

Pivoting to peer and friend support, Feiring et al. (2000) offers insight into the relationship between shame and peer-acceptance. CSA-related shame was associated with lower feelings of peer-acceptance but did not impact the size or supportiveness of friendship networks. Generalised shame was found to be associated with less satisfaction with support from same-sex friends and fewer close friendships. However, it did not lead to a reduction in the size or supportiveness of friendship networks. Interestingly, this study found that neither CSA-related nor general shame, at baseline or 1-year follow-up, were associated with perceived peer-competence outcomes, indicating that shame may not directly influence how survivors perceive their own competence in social interactions.

Neufeld et al. (2012) investigated the relationship between CSA-related shame and the perceived availability of social support, indicating that shame may contribute to a perceived lack of support among survivors. In contrast, Persons et al. (2010) found that CSA-related shame was positively associated with the perceived availability of support, suggesting that some survivors may seek out support to cope with their shame. A related study (Feiring et al. 1998) found that the *source* of support was crucial in understanding the prevalence of shame among CSA survivors. Children who relied solely on support from friends exhibited higher levels of shame compared to those who received support from parents or both parents and friends. Perhaps contrary to expectations, Feiring and Taska (2005) found no direct association between abuse characteristics

or satisfaction with support from caregivers at the time of abuse discovery and subsequent levels of abuse-related shame—potentially indicating that shame may persist independently of immediate post-abuse circumstances.

Resilience is one of the few positive traits studied in relation to CSA and shame; Ginzburg et al. (2006) conducted a study investigating the connection between shame, guilt, and resilience. Shame was found to positively correlate with guilt and negatively correlate with resilience, emphasising the debilitating effect of shame on emotional well-being; however this negative correlation might also imply that there is an opportunity for resilience to act as a buffer against shame if leveraged at the right time.

In the context of family dynamics, Ginzburg et al. (2006) found that women who were abused by a first-degree family member experienced significantly higher levels of shame compared to those abused by unrelated individuals; Kallstrom-Fuqua et al. 2004's findings relate to this, as they emphasise the relationship between shame and feelings of betrayal, powerlessness, and maladaptive relationships. Kim et al., 2009 also showed that shame partially mediated the connection between CSA and family conflict.

Michalopoulos et al. (2015) draws attention to another critical aspect of shame—its role in alienating and isolating survivors—finding that only those with extreme levels of shame tend to believe they are the only ones who have experienced CSA, further isolating them from potential support networks. This may be one reason why Kessler and Bieschke 1999 found that shame mediated the relationship between CSA and adult victimisation - its encouragement of isolation.

Two studies exploring the role of HIV in the CSA-shame landscape (Neufeld et al., 2012; Willie et al., 2016) found that HIV-related shame, but not CSA-related shame, was associated with a lower quality of life. Such studies highlight the unique impact of different types of shame on overall well-being. Moreover, Willie et al. (2016) suggests that for men, living with HIV infection

may have a more significant impact on shame and anxiety symptoms than past childhood abuse, suggesting that even in people with a CSA history, causes of shame can be multifaceted.

Finally, problems relating to sexual behaviour (namely sexual arousal and satisfaction) were highlighted by Wilson and Wilson (2008). Unwanted sexual fantasies leading to shame were shown to affect an individual's enjoyment of masturbation and sexual intimacy with a partner, resulting in decreased frequency. While the social and behavioural difficulties resulting from CSA and shame are varied, and to an extent dependent on individual personality traits and environmental circumstances, research generally seems to agree that stability of relationships (familial, peer, or romantic) in the short and long term is at least somewhat, if not significantly, compromised in CSA survivors compared to those without CSA experiences. This pattern also dovetails with findings for other types of adverse childhood experiences (ACEs), particularly other types of abuse (Babad et al., 2022; Lipscomb et al., 2019, 2022).

2.3.4.2.3 *Ethnic/Cultural Factors Affecting the CSA-Shame Relationship*

While relatively few studies examined the CSA-shame relationship in ethnic minority or Global South populations, these studies brought to light some important differences in the experiences of shame for survivors of varying ethnicity and culture.

Feiring et al. (2001) revealed important findings regarding the relationship between ethnicity and CSA-related shame. Hispanic CSA survivors were found to experience higher levels of general shame compared to survivors from other ethnic groups. This suggests that cultural factors (such as higher levels of collectivism, or a culture of 'honour') contribute to heightened shame in this population. However, no significant differences were observed among ethnic groups concerning CSA-specific shame, indicating that the emotional response to the abuse itself may be more universally experienced across ethnic backgrounds.

Furthermore, Feiring, Coates, and Taska's study highlighted ethnic variations in the relationship between CSA severity and CSA-related shame. For Hispanic and African American survivors, there was no clear correlation between the severity of the abuse experienced and the level of shame reported. In contrast, European American survivors in the high-severity CSA group exhibited more shame compared to their counterparts in the low-severity CSA group. These findings suggest that the intersection of ethnicity and CSA severity can influence the experience of shame, with European American survivors showing a more pronounced response to the severity of the abuse.

Moving to studies involving non-WEIRD populations or populations outside the United States, Michalopoulos et al. (2015) examined the experiences of Zambian girls with experiences of CSA. Their research illuminated that girls who have experienced CSA are likely to endure extremely high levels of shame, and that regardless of whether they admitted their experience of CSA to the researchers, they suffered significant levels of shame. In a study conducted with a population of indigenous Australian children (Hamilton et al. 2016), it was found that shame responses were present in 27% of the interviews. Notably, shame was reported to manifest in both explicit and implicit ways during interviews, with 52% of shame responses being implicit and 30% being explicit. Moreover, 18% of participants mentioned feeling shame during the abuse itself, shedding light on the enduring and pervasive nature of this emotion in the context of CSA among Aboriginal survivors. One significant finding from this study is that children who expressed shame during interviews spoke, on average, the same amount about their abuse experience as those who did not express shame. However, it was noted that it required more effort to elicit a disclosure of sexual abuse from children who expressed shame within the interviews compared to those who did not; creating safe and supportive environments for survivors to share their experiences seems to be an urgent need at the earliest possible stage—the section below on disclosure emphasizes this further.

2.3.4.2.4 Shame as a Barrier to the Disclosure of CSA

Findings from various studies highlight the very apparent relationship between shame and the disclosure of CSA. Münzer et al. (2016) found that shame was reported as the most frequently mentioned barrier against disclosure by children and adolescents. Bonanno et al. (2002) and Bonanno et al. (2003) showed that non-disclosure and non-voluntary disclosure are associated with increased feelings of shame, indicating that shame can serve as a significant emotional barrier to revealing instances of abuse. Daral et al. (2017) further underscore this point, emphasising that shame can act as a substantial impediment to disclosure, making it difficult for victims, particularly children, to come forward to disclose their experiences. Hamilton et al., (2016) support this, finding that it requires more effort to elicit a disclosure from children who express shame during interviews compared to those who do not.

Hershkowitz et al. (2007) offers insights into the factors that influence shame and fear around disclosure. Their findings reveal that children are more likely to experience fear and shame in the context of disclosure when the perpetrators are familiar, the abuse is serious and repeated, and when parents typically react with anxiety rather than calm. Additionally, they highlight that delayed disclosure, and having multiple perpetrators (as also found by Kellogg, 1995) are often associated with increased shame. Gender differences appear in Kellogg and Hoffman (1995), which found that females are more likely to delay disclosure due to shame compared to males. Moreover, embarrassment emerges as a common reason for delaying or avoiding disclosure, as noted by Kellogg and Huston (1997) and O'Riordan et al. (2003). In a unique finding, Negrao et al. (2005) revealed that CSA participants who chose to disclose their abuse often expressed shame verbally, while those who did not disclose tended to display shame nonverbally.

Finally, Michalopoulos et al. (2015) found that in a sample of Zambian schoolgirls, shame scores did not significantly differ between the girls who claimed to have suffered CSA and those who did not, even though all *had* experienced CSA. This finding also sheds light on potential

cultural factors that might impact the way in which CSA disclosures are handled, and how the concept of ‘saving face’ (Dong et al., 2013; Eriksson et al., 2017) or avoiding external *shaming by others* (as opposed to internalised shame), may be a priority for survivors in some communities.

2.3.4.2.5 Bodily Shame

Within the discourse of shame as it relates to CSA, there is a move to differentiate specific types of shame. One of the main sub-categories emerging in the literature is bodily shame. As the term suggests, this type of shame is focused on parts (or the entirety) of one’s body; viewing, feeling, or thinking about the body part(s) in question elicits responses such as disgust and feelings of brokenness or defectiveness (Gilbert & Miles, 2002). Focusing specifically on bodily shame in the context of CSA might be useful in determining an individual’s risk factor for specific psycho-social problems.

A number of studies show an association between CSA experiences and increased levels of bodily shame (Borgmann, 2014; Dyer, 2015; Milligan & Andrews, 2005; Talmon & Ginzburg, 2018; Talmon & Ginzburg, 2017; Waller et al, 2001; Watson et al., 2013); one cross-sectional study (Talmon & Ginzburg, 2018) found evidence consistent with the hypothesis that the disruption of normal body boundaries mediated the CSA-bodily shame relationship. However, due to the cross-sectional nature of the study, evidence was not provided that this was a causal relation, which remains to be determined. The specific body areas associated with the abuse trigger higher levels of shame, and women reported more bodily shame than men (Dyer, 2015; Talmon & Ginzburg, 2018). The latter finding may be explained by the differences in the socialisation of girls versus boys (in that there is greater scrutiny of girls’ and women’s bodies, and a greater emphasis on boys suppressing negative emotions/body image concerns; Amin et al., 2018).

Bodily shame was found to partially mediate the relationship between CSA and self-harm (Milligan & Andrews, 2005), and to mediate the relationship between body surveillance and

alexithymia (Watson et al., 2013). Further within the context of eating disorders, core beliefs of CSA survivors that were based in shame and defectiveness partially mediated the relationship between CSA and vomiting (with beliefs of defectiveness positively correlating with vomiting frequency, depression, and dissociation) (Waller et al., 2001).

Finally, in an interesting finding, two separate studies (Milligan & Andrews, 2005; Talmon & Ginzburg, 2017) demonstrated correlations between CSA and bodily shame, but not characterological (related to one's inherent personality and character) or behavioural (actions such as hiding, avoiding social interaction, shame-coded body language) shame. These findings indicate the need for further research into the different facets of shame, given the apparent links between bodily shame and severe psychological and medical issues.

2.3.4.2.6 Self-Blame

As discussed in the introduction, self-blame often overlaps with shame, and in some circumstances (i.e. when it comes to characterological self-blame), seems to be used and explained very similarly to shame. Thus, it was important for this review to highlight two studies that investigated characterological self-blame even though they do not explicitly study 'shame'.

In the first of these studies, Jehu (1989) found that survivors retrospectively rated their characterological self-blame as having been higher during childhood compared to their current adult selves. This suggests that survivors may undergo a shift in their perception of self-blame as they grow older and potentially engage in processes of self-reflection and healing. Furthermore, Jehu's research revealed significant associations between characterological self-blame, depression, and self-esteem among adult survivors. In particular, characterological self-blame was positively correlated with depression. Conversely, it was negatively correlated with self-esteem, underscoring the detrimental impact of characterological self-blame on survivors' self-worth and self-concept. Interestingly, retrospective ratings of characterological self-blame as children were

found to be negatively correlated with self-esteem but not associated with depression. This suggests that the influence of characterological self-blame on self-esteem may be particularly salient during earlier years of development and highlights the enduring consequences of childhood experiences on survivors' self-perception.

Mokma et al. (2016) also delved into the long-term implications of characterological self-blame among CSA survivors. Its findings revealed that characterological self-blame was positively correlated with global levels of self-blame and post-traumatic stress disorder (PTSD) symptoms, but not with alcohol use. Moreover this research unveiled a concerning pattern—characterological self-blame predicted both substance-facilitated and forcible sexual revictimization in adulthood, underscoring the enduring vulnerability of survivors who harbour characterological self-blame, as it may contribute to a heightened risk of retraumatization. This study emphasised that in terms of sexual revictimization, CSA-specific behavioural and characterological self-blame play a more substantial role than global self-blame.

Considering factors such as the frequency of victim-blaming after experiences of sexual assault both in childhood and adulthood, understanding the nuances of self-blame (and its inherent relationship to shame), and the ways in which society perpetuates it, is crucial for developing effective therapeutic interventions and support systems for this population.

2.3.4.2.7 Incest

A number of studies addressed specifically incestual CSA. These studies found that incest survivors were more likely to feel shame than people who suffered non-incestual CSA (Stroebe et al., 2012). Some of these studies highlighted factors that could increase shame. For example, in a study of mother-son incest, Kelly et al. (2022) found that participants who reported some initial positive feelings in relation to the incest also reported concurrent feelings of shame. Importantly, there was some evidence suggesting that shame might be one way in which CSA can have

intergenerational effects, with study of mothers who were childhood incest victims finding that shame could hinder their communication with their children (Cohen, 1995).

2.3.4.2.8 Mitigating Shame in CSA Survivors

Many studies in this review investigated the effectiveness of various clinical interventions on the reduction of CSA-related or general shame over time. The interventions investigated tended to be variations on existing therapeutic protocols such as CBT, DBT, compassion-focused therapy, and group psychotherapy.

A few studies (Borgmann et al., 2014; Bowyer et al., 2014; Cohen et al., 2004; Garg et al., 2017; Wilson & Wilson, 2008) are of particular note due to the specific nature of the interventions used, and the potential these interventions may have to mitigate the adverse effects of shame on a larger scale.

Cohen et al. (2004) investigated the effectiveness of a trauma-focused CBT (TF-CBT) intervention and Child Centered Therapy (CCT) in reducing PTSD symptoms and other negative emotions such as shame in 229 adolescent survivors of CSA. The TF-CBT protocol (developed by the study's authors) involves the incorporation of psychoeducation, feeling expression and coping skills, gradual exposure/creating a trauma narrative and parent-child sessions in addition to standard CBT protocol for children. The alternative option, CCT, is based in large part on the gradual establishment of trust between the child, the parents, and the therapist, whereby the course of therapy and the topics discussed in sessions are determined by the child and parents, rather than the therapist. Contributions from the therapist are therefore limited to occasional clinical interpretations and meaning-making, reflection, and active listening. Results from this study demonstrated that the TF-CBT group showed significantly greater improvement in PTSD symptomatology, interpersonal trust, and shame, among other outcomes studied, than the CCT

group. Additionally, it was suggested that shame be one of the factors investigated in future research as a potential mediator of treatment outcome.

A modified CBT protocol was also used in Borgmann et al. (2014), which investigated the effects of conducting a standardised mirror confrontation task (developed for the assessment and treatment of eating disorders by Vocks et al., 2007) on the levels of body-related emotions (in particular, bodily shame) and acute dissociation in 17 adult female survivors of CSA diagnosed with PTSD. The mirror confrontation task involved participants focusing on 12 areas of their bodies in a particular sequence for 50 seconds each. Participants were asked to fill out several scales measuring emotion ratings, distress relating to dissociation, and a thoughts checklist at multiple timepoints before and after the mirror confrontation task. In relation to shame, the study concluded that in the group of CSA survivors who also had PTSD, the mirror task triggered significant aversive emotional responses, namely shame, disgust, and anger. The task also increased dissociative states in this participant group. The authors suggest that the explicit inclusion of body-related dimensions (such as having patients engage in the mirror confrontation task or something similar) in existing clinical interventions such as CBT and even general psychoeducation could serve to normalise survivors' experiences of these aversive emotions and directly address emotions like shame by bringing them to the forefront during therapy sessions.

Both Cohen et al. (2004) and Bowyer et al. (2014), while exploring slightly different types of CSA-related shame, recommend the modification of existing CBT protocols to explicitly address certain topics, namely shame and specific events within the survivor's trauma narrative. The findings of these studies suggest that rather than allowing certain emotions and cognitions to remain 'under the surface' during the course of therapy (perhaps due to concerns of causing additional distress to patients) and relying on the potential benefits of treatment to trickle down to these emotions as well, it would be much more efficient (and arguably more ethical) to directly engage with these topics during the course of therapy, particularly if there is evidence that shame

and similar self-conscious emotions actually mediate therapeutic outcomes. Furthermore, considering that in many cases short-term interventions are used due to monetary and staffing constraints, time is of the essence when attempting to mitigate the most impactful outcomes of CSA (especially in children, given the long-term impacts of shame and guilt mentioned in the previous section).

Finally, Bowyer et al. (2014) utilised an adjusted CBT intervention that incorporated a compassion-focused therapy (CFT) protocol in an attempt to reduce shame in an adolescent survivor of CSA. Over eight months of treatment, a 17-year-old female was administered TF-CBT (Ehlers et al., 2005; Smith et al., 2007) and CFT (Gilbert, 2010) in order to change her responses to a specific disgust-based flashback. Previous to beginning this protocol, the patient experienced severe feelings of shame and disgust when she was asked to access the flashback, as she had not developed suitable coping mechanisms and cognitions to deal with the fallout of reliving the flashback; she therefore needed a way to access this memory while ensuring that at the end of the exercise she would be left with more soothing or neutral feelings. In this new protocol, the patient was given psychoeducation on the origins of CFT (Gilbert, 2000) and the benefits of ingraining a compassionate mindset, after which the therapy sessions focused on reframing her experience of accessing the disgust-heavy flashback within a compassion-focused mindset.

Post-intervention assessments saw significant reductions in scores for PTSD (Post-Traumatic Diagnostic Scale; Foa, 1995), shame (Other as Shamer Scale; Goss et al., 1994), and feelings of self-hatred (Forms of Self-Criticizing/Attacking and Self-Reassuring Scale, FSCRS; Gilbert et al., 2004). The FSCRS also indicated a significant increase in the patient's ability to reassure and comfort herself. While wider conclusions cannot be made from this particular study, it offers a unique opportunity to more deeply explore the role of compassion in regulating shame and related feelings in a way that many of the cross-sectional studies discussed below are not able to—it also showcases the ways in which a compassion-based protocol can be tailored to individual patients.

In the context of DBT, shame was found to be lower after treatment compared to pre-treatment levels (Garg et al., 2017). Similarly, both trauma-focused and present-focused group psychotherapy have demonstrated significant reductions in shame (Ginzburg et al., 2009). Interestingly, this same study (Ginzburg et al., 2009) noted that an increase in shame for women undergoing trauma-focused and present-focused therapy did not necessarily lead to an increase in PTSD symptoms. However, for the women in the wait-list group, an increase in shame generally corresponded to an increase in PTSD symptoms.

In a study investigating the effectiveness of support groups for CSA survivors diagnosed with HIV, the level of CSA-related shame experienced by participants determined their therapeutic outcome (Hansen et al., 2016). Those with low CSA-related shame saw a 20% clinical improvement when exposed to an existential philosophy-based support group (based on the work of Yalom, 1985). Conversely, participants with high CSA-related shame experienced a higher rate of clinical improvement, with 54% benefiting from the support group intervention. Moreover, within the high CSA-related shame subgroup, those with low dissociation saw an 82% clinical improvement, while 32% with high dissociation noticed improvements.

Shame was identified as a motivating factor for participation in self-help groups by 33% of individuals in a study by Rahm et al., (2013). Furthermore, the effectiveness of interpersonal psychotherapy in reducing shame was evident as shame improved more over time as a result, compared to usual care (Talbot et al., 2011).

Finally, in therapeutic contexts where unwanted sexual arousal was reduced, such as through self-administered aversive treatment, a concurrent decrease in shame was also observed (Wilson & Wilson, 2008). Though there is no consensus on the most effective treatment modalities for CSA-related shame, what the research makes clear is that some form of structured, clinical intervention, where the survivor is encouraged to talk, thereby having their experience (perhaps for the first time) validated, leads to better outcomes (reduced shame) than no treatment at all.

2.3.5 Qualitative Findings

2.3.5.1 *Descriptive Information for Qualitative Studies*

Eighty-one of the 168 studies included in this review were qualitative in design. These studies included a total of 2,926 participants. Including such studies addresses one of the main suggestions made by MacGinley et al. (2019), namely for future reviews to investigate more qualitative research. One of the challenges in searching for qualitative studies in relation to shame and CSA is that in much of the research, shame is discussed indirectly. Studies may allude to shame, without it being explicitly described as shame and, in many cases, components of shame (such as avoidant, hiding behaviours, a feeling of dirtiness, or disgust at one's self) form parts of discussions within many interviews. Hence in order to provide a more accurate summary of research in the area, the scope of this review was widened to screen these types of studies as well, some of which are part of the final selection. A few case studies were also included in the final cache of studies due to the detail in which they explore shame.

Mean age was reported in 36 of the 81 studies, while an age range alone was given for 25 studies. Seventeen studies lacked any information on age beyond mentioning that the participants were younger or older than 18 years. The mean age for all studies was 33.7 years, with a range of means between 10 and 59.5 years. The sample sizes of the studies ranged from 1-460 participants, with a mean sample size of 37, and a total combined sample size of 2926. Sixty-nine out of the 81 studies (85%) were conducted in WEIRD samples (compared to 97.5% of quantitative studies), perhaps indicating the potential for qualitative research methods to be more readily deployed in a variety of settings. A significant portion of the remaining qualitative data are drawn from marginalised populations (within the already marginalised population of CSA survivors). Nineteen out of 81 studies (23.5%) had samples that were over 50% male, of which 18 studies had samples that were 100% male (one study in the qualitative selection did not report information on the sample's gender). This is a significant increase in the proportion of male participants from the

selection of quantitative studies, where only 8.6% of studies had samples where over half (or half) of the participants were male.

Given the designs of these studies, measures/tools to assess shame were not utilised. Instead, the reviewers screened each potentially-relevant study from the initial database search in order to determine: a) whether shame was a topic that was implicitly or explicitly explored and b) the extent of the discussion on shame in the study (i.e. if there was enough substance to analyse in the review). Studies were chosen for final inclusion based on these criteria.

The most common theoretical approaches, as described in the studies themselves, were grounded theory (Strauss & Corbin, 1997) and phenomenological analysis (Smith et al., 2012), while the most common analysis methods were thematic analysis and content analysis. Case studies were categorised as a separate approach in and of itself, given the uniqueness of each case study's analysis. This sample of studies reflects the dominance of grounded theory and phenomenological analysis in general, as they are the two most-utilised approaches within qualitative research (Urcia, 2021). There does not appear to be a relationship between the sample size of a study and the approach used. While many studies described their methodology as 'thematic analysis', this term was often used as more of a general descriptor, rather than an actual reference to Braun and Clarke's (2006) reflexive thematic analysis method (of course, many of the studies included date from before 2006, the year of Braun and Clarke's seminal publication). A variety of methods falling under the general 'thematic analysis' category was used in these studies, generally indicating an inductive process of coding.

2.3.5.2 Thematic Findings for Qualitative Studies

Salient themes resulting from the set of qualitative studies generally parallel those extracted from the quantitative studies, though a couple of areas diverge in the level of detail afforded to them (in that some themes are elaborated on in more detail in qualitative studies). Negative psycho-

social outcomes were a focus of the majority of studies to some extent, while many studies also spotlighted the effects of shame on disclosure, bodily shame, and the link between shame and self-blame and guilt. The experience of shame in male CSA survivors is explored in-depth, and cross-culturally, in several of the studies, offering important insights into an often overlooked population.

Given the higher number of studies (compared to the quantitative section) taking place in non-WEIRD settings, and given the nature of qualitative methodologies, there is richer data on cultural components of shame, including discussions on familial honour, marriage and relationships, and social stigma, discussions of which can elucidate differences in how CSA survivors are treated in varying WEIRD and non-WEIRD settings. Finally, as several studies take place in clinical settings, there is significant discussion on potential shame-mitigating factors, and more in-depth data on how survivors experience different therapeutic approaches.

2.3.5.2.1 *Negative Self-Perception and Shame Behaviours*

One of the main commonalities in many of the qualitative studies is a clear link between the experience of shame in survivors and elements of negative self-perception and self-esteem. Many studies report survivors thinking of themselves as ‘dirty’, ‘damaged’, ‘worthless’, and ‘powerless’; an overall, permeating sense of ‘badness’ or ‘defectiveness’ is a frequent experience cited in these studies (Ballantine, 2012; Canavan et al., 1992; Cavanaugh et al., 2015; Choudhary et al., 2019; Chouliara et al., 2014; Colarusso, 2009; Collins et al., 2014; Darlington, 1995; Deering & Mellor, 2011; Draucker & Petrovic, 1996; Fontes, 1993; Hodge & Bryant, 2019; MacIntosh et al., 2016; Myers, 1989; Oaksford & Frude, 2004; O’Leary & Gould, 2009; Payne et al., 2014; Senn et al., 2017; Singh et al., 2013; Valerio & Lepper, 2009). A lack of, or low, self-esteem also appeared as an almost-ubiquitous trait of the survivors in these studies, supporting data from the quantitative studies. Relating to this, a lack of sense of self was also associated with CSA and to some extent,

with shame. In her in-depth interviews with 10 Australian (non-indigenous) female survivors of intrafamilial CSA, Darlington (1995), highlights this lack of self as a central outcome of her study:

'Some of the women clearly identified a time when they had no experience of self, as separate from others, or as having the capacity to act in their own interests. While they spoke of themselves as being highly connected to the needs and wishes of others, they lacked the capacity to engage actively with others.' (Darlington, 1995, p. 12)

The absence of the 'self' as a separate entity from others seems to be a fundamental consequence of intrafamilial CSA in particular, perhaps due to the already close-knit nature of relationships between family members. This dynamic is akin to enmeshment (the blurring of boundaries between family members to the point of loss of autonomy and sense of identity)--and while it has been shown to occur in families where abuse is not present, it seems to occur at a much higher prevalence in children experiencing abuse by family members (Kivisto et al., 2015). In particular, enmeshed parent-child relationships have been associated with the occurrence of CSA both within and outside the family (Reinemann et al., 2003). While the direction of the relationship between dysfunctional family characteristics and the experience of CSA by a child in the family has not been confirmed, it is clear that the existence of both variables in the family dynamic heavily influences the child's ability to form a separate identity and to assert their own desires. Furthermore, Chouliara et al. (2014) points out people-pleasing tendencies in CSA survivors, which supports Darlington's (1995) observations that survivors are 'highly connected to the needs and wishes of others'.

Certain shame behaviours, in particular avoidance-related ones, are seen commonly in survivors. Reduced eye-contact, turning away from the interviewer or therapist, withdrawal in social contexts, avoidance and hiding of one's feelings, isolation in childhood and adulthood, and general tendencies of secrecy, have been frequently observed across culture and gender; survivors are afraid that their 'bad self' will be exposed (Ballantine, 2012; Colarusso, 2009; Contreras et al.,

2017; Darlington, 1995; Deering & Mellor, 2011; Draucker & Petrovic, 1996; Heiman & Ettin, 2001; Hodge & Bryant, 2019; Hohendorff et al., 2017; Myers, 1989; O’Leary & Gould, 2009; Phelan, 1995; Saha et al., 2011; Wang & Heppner, 2011). In their study of male CSA survivors, Draucker and Petrovic (1996) highlighted a phrase used by some survivors to describe their lives before accessing counselling: ‘living in the dungeon’, an apt description of the feeling (and too often, the reality) of being cast out of society that many survivors experience.

2.3.5.2.2 Family Honour

Concern with family and society honour, and the damage that may be caused to it, was a primary theme of several studies conducted in honour-based contexts, and in many studies on male survivors. The emphasis on honour is also reflected in the way a survivor’s community treats them after disclosure or revelation of the abuse (Adinew et al., 2018; Ahmed et al., 2009; Choudhary et al., 2019; Easton et al., 2014; Fontes, 1993; Luo, 1998; Taylor & Norma, 2013; Timraz et al., 2019; Tsun, 1999; Xiao & Smith-Prince, 2015; Zalcberg, 2017). Honour- and dignity-based cultures (which can be found to some extent in all regions of the world, but are often associated with high levels of religious adherence, collectivism, and patriarchal values) typically display certain key characteristics: placing immense value on the defence of individual and community reputation; willingness to retaliate against attacks on one’s reputation or moral character (to protect reputation, sometimes at all costs), scarcity of certain relevant resources, and a lack of effective centralised law-enforcement within the communities (Cohen et al., 1996; Nowak et al., 2016; Uskul et al., 2019).

Given the shared sense of identity that often permeates members of any self-ascribed community, it follows that honour-based cultures, in addition to wanting to protect individual reputations, are additionally preoccupied with how an individual’s behaviour reflects on the rest of the community (Uskul et al., 2019). When combined with elements of patriarchy, filial piety (the expectation of family members to act in the interest of family unity above all else), and the

treatment of female virginity/sexuality as a scarce resource (perhaps as a way of ensuring paternity), this gives rise to a context in which victims of sexual abuse are pressured to be silent about their experiences in order to maintain the familial structure (Haboush & Alyan, 2013; Uskul et al., 2019).

In their investigation of cultural factors affecting Arab-American CSA survivors, Haboush and Alyan (2013) found that expectations of filial piety shaped survivors' decisions to not disclose their abuse. Children instead tended to deal with the aftermath by using self-blame to justify the abuse. This research also observed that sometimes, in cases in which the child does disclose CSA, family members may respond by shaming and blaming the child for the abuse—this can be traced back to the cultural pressure in honour-based societies to preserve the reputation of the family/community at the expense of the individual. A moral failing is attributed to the child's character to make it clear that the 'defect' lies in the individual child rather than in the family unit. In addition, from a practical standpoint it may be seen as more important to protect the reputation of an adult abuser in the family, as it is more likely that the adult holds financial power and societal clout, rather than the child (Haboush & Alyan, 2013).

Shaming behaviours towards CSA survivors in these honour-based contexts was also highlighted in Adinew et al. (2018), which presented a case study of an Ethiopian woman with a history of intrafamilial CSA. When the abuse was eventually revealed to the girl's community, some community members responded by blaming the girl for the repeated assaults, while others further sexualised her, thereby attributing the abuse to factors inherent to the girl's character:

"Some male students even asked me to make out with them saying I had nothing to lose anymore. No one tried to help me, including the teachers, rather they made fun of me; some even accused me of seducing my mother's husband." (Adinew et al., 2018, p. 4)

In another study conducted with South Asian women in the UK, Ahmed et al. (2009) cited family honour as a major factor leading girls and women to stay silent about experiences of sexual abuse. The accounts reported in this study affirmed previous research into South Asian (C)SA survivors' experiences post-abuse, highlighting the burden daughters often carry to uphold the family's reputation and how this burden works against victims of SA. Again, family honour is linked to the conduct of, or more accurately, the perception/interpretation of the behaviours and supposed moral characters of individual family members. An insistence on respect for elders under all circumstances seems to guide many survivors' actions as well. Two participants sum up their experiences opening up to their families about domestic abuse:

"she [mother] worries too much about family, what people are going to say, oh my god what's this auntie going to say, they're going to say it's your fault." (Survivor 5)

"Oh god . . . they [family] wanted to brush it under the carpet for the shame of it you know. (Survivor 6)

"Like with my mum she's more like oh know you should stay with it stay with it, family name, family name, you're going to put your dad's name in the ground and look at the high izzat [honour] he brought up and stuff like that, it just doesn't work. Not with me anyway . . ." (Survivor 5) (Ahmed et al., 2009, p. 18)

Survivor 6's account in particular highlights the perception of shame being 'contagious'; the family is at risk of the survivor's shame transferring onto them if the shameful acts (in this case the experiencing of abuse) are exposed or disclosed. Considering that the survivor's shame itself often stems from external messaging around the abuse (messages that victims are damaged or morally corrupt, that they are somehow fundamentally deserving of the abuse), the fear of contagious shame seems to become circular since much of the shame the survivor feels may

originate from the family. Nevertheless, dynamics such as this in the context of honour-based communities serve to ostracise and stigmatise survivors in the name of communal unity.

2.3.5.2.3 Stigma

Societal stigma against CSA survivors emerged as a major topic of discussion in several studies, many of which are mentioned above in the section on family honour (Adinew et al., 2018; Ahmed et al., 2009; Choudhary et al., 2019; Contreras et al., 2017; Dickson-Gómez et al., 2006; Draucker & Petrovic, 1996; Easton et al., 2014; Erdmans & Black, 2008; Fontes, 1993; Hickie & Roe-Sepowitz, 2014; Hlavka, 2017; Jung & Steil, 2012; Taylor & Norma, 2013; Timraz et al., 2019; Tsun, 1999; Xiao & Smith-Prince, 2015; Zalcborg, 2017). In the studies that deal with or touch on this theme, stigma manifests in a variety of ways, both internally in survivors, and externally via the treatment of survivors by their environments. Some of the more common forms of stigmatising actions towards survivors are: social isolation, bullying, blame for the abuse, emasculation, and being deprived of a self-defined identity.

Common internalising consequences of stigma range from substance abuse, destruction of self-esteem, self-doubt, hiding and other avoidant behaviours, social withdrawal, and involvement in sex work later in life. Overall, the results of these studies point to a two-way relationship between stigma and shame, with each feeding into and worsening the other—stigma and shaming from a survivor's surroundings leading to shame and withdrawal from society, which is then linked to social, psychological, and behavioural outcomes that further elicit stigma (such as engaging in sex work).

Furthermore, survivors may be treated differently depending on the type of CSA they experienced. In a study of adolescent survivors of sex trafficking, Hickie and Roe-Sepowitz (2014) found that while communities had a sympathetic attitude towards CSA survivors in general, when it came to girls who had been forced into sex work, there was still a tendency to stigmatise them,

and victims would sometime be labelled as “‘sluts,’ ‘hos’, or other derogatory terms”, being further stigmatised and written off from mainstream society if they continued to work in the sex industry as adults (Hickle & Roe-Sepowitz, 2014, p. 107). Cases in which the victim of abuse is viewed by their community as the ‘instigator’, such as the Ethiopian girl profiled by Adinew et al. (2018) seem to generate more stigma and ostracisation; the girl in question eventually dropped out of school for a period of time due to the harassment and stigma she was receiving. The consequences of falling behind in school may have then further stigmatised the survivor in the future.

2.3.5.2.4 Shame and Stigma in Male Survivors

Several qualitative studies focused on majority-male or male-only samples, a departure from the highly female-centric quantitative set of studies (Choudhary et al., 2019; Draucker & Petrovic, 1996; Durham, 2003; Easton et al., 2014; Fontes, 1993; Friedman, 1994; Gagnier & Collin-Vézina, 2016; Harris & Dunn, 2019; Hlavka, 2017; Hohendorff et al., 2017; Jackson, 1994; Lisak, 1994; Myers, 1989; O’Leary & Gould, 2009; Payne et al., 2014; Rapsey et al., 2017; Sigurdardottir et al., 2012; Sorsoli et al., 2008; Weille, 1997; Zalcberg, 2017). This body of research shines light on some of the unique challenges relating to shame and stigma faced by male CSA survivors.

Firstly, one of the most common consequences faced by male survivors is a sense of emasculation or loss of masculinity, stemming from the powerlessness they felt during the abuse. As Hlavka (2017) points out in her study of male survivors (where survivors of different races were interviewed), power is highly associated with masculinity, and the loss of power is, in the eyes of most patriarchal communities, the loss of the essence of masculinity. Because of this link, while the violation of bodily and mental autonomy is deeply damaging to people of any gender, male-identifying survivors may find it more difficult to deal with this particular consequence of CSA. The seeming loss of a core part of their identity, signals to the survivors damage to a fundamental aspect of self—from here, the feeling of shame becomes pervasive in the survivors’ lives.

In her interviews, Hlavka (2017) found that many young men found it hard to recognise their experiences as sexual assault, having been brought up with prevailing cultural ideologies implying that men, particularly teenagers and adults, cannot be victims of sexual violence. Some of the young men interviewed by forensic psychologists refused to disclose their abuse experiences despite authorities having evidence such as confessions or witness accounts. In one case where there was corroborative evidence and a disclosure from another victim of the same abuser, the 14-year-old boy being interviewed was asked what he would do if someone touched him inappropriately:

“Interviewer: What would you do if [someone gave you touches that made you uncomfortable]?”

Derek: Um, like, I’d fight them. I’d fight them away and punch them.

Interviewer: Okay, and what if you couldn’t fight them away?

Derek: I would (2.0 seconds pause) I-I don’t know.

Interviewer: Do you think that it’s possible that someone could try to touch another person and they wouldn’t be able to get away or do anything about it?

Derek: No, not that I’m aware.

Interviewer: No? (1.5) Well, cause sometimes stuff like that happens, I mean, sometimes people can’t get away and can’t tell and, if something happens to someone and they don’t tell, who’s fault do you think it is?

Derek: Um, the- ah, the person that it happened to, the person that got touched.

Interviewer: You think it’d be their fault? Why do you think that, Derek?

Derek: Cause they didn't, they didn't do it right. They didn't, well, fight or be strong enough right away." (Hlavka, 2017, p. 8)

Throughout this exchange, Derek performs masculinity via his responses, which reflect what he thinks is the manly and honourable way to behave in such a situation. By attributing fault to the victim in the 'hypothetical' scenario in which the victim of abuse is not able to fend off the abuser, in a way Derek seems to be viewing his own CSA experience from the eye of others in his community, preempting their reactions. He is aware of the unfortunate fact that many people, particularly other men, would view being sexually abused as a huge character flaw, one deserving of being shamed.

Another concern cited by many male survivors when it comes to their reluctance to disclose, is the fear of being perceived as gay. The confluence of homophobia and misogyny create an incredibly strong barrier to disclosure, as discussed in Easton et al. (2014). The interviews in this study reveal the core of this fear: that an assumption of homosexuality somehow takes away from their masculinity (as a result of the perceived loss of power, or 'feminising' effect of rape or penetration). There exists a tendency in many communities to relegate gay men to the realm of 'femaleness', in large part due to the association of sexual acts between men with being penetrated (often seen as taking on the woman's sexual role); this societal mindset then allows for the shaming of male survivors of (C)SA, and for the pinning of blame for the abuse on a perceived lack of masculinity in the victim.

2.3.5.2.5 Disclosure and Shame

The theme of disclosure in relation to shame is central in the body of qualitative evidence, supporting the findings in the quantitative studies. The research indicates that shame, and more specifically the fear of shaming reactions from others, acts as a powerful barrier against disclosure for survivors of abuse across cultures, and that the act of disclosure can be an equally powerful tool in reducing survivors' shame (Bermudez et al., 2018; Bryan & Albakry, 2015; Canavan et al.,

1992; Cavanaugh et al., 2015; Choudhary et al., 2019; Chouliara et al., 2014; Contreras et al., 2017; Crisma et al., 2004; Easton et al., 2014; Fontes, 1993; Fornari et al., 2018; Friedman, 1994; Gagnier & Collin-Vézina, 2016; Harris & Dunn, 2019; Hlavka, 2017; MacIntosh et al., 2016; McElvaney et al., 2014; Sorsoli et al., 2008; Xiao & Smith-Prince, 2015).

Studies such as that conducted by Bermudez et al. (2018) (on adolescents from the Democratic Republic of Congo in a Rwandan refugee camp) and Bryan and Albakry (2015) emphasise the salience of shame when it comes to the avoidance of directly addressing or describing abuse events. This is further complicated by the secrecy surrounding abuse that is often encouraged by the abuser, and the inability of survivors to disclose their experiences, as found in research on sibling incest by Canavan et al. (1992). The impact of shame extends beyond the act of disclosure itself, being influenced by the reactions of others to the disclosure, where blame and disbelief from those survivors disclose to often exacerbate the survivor's sense of shame and guilt, as seen in Cavanaugh et al. (2015) and Choudhary et al., (2019).

However, while fraught with challenges, disclosure emerges as a potential first step in the pathway for recovery from shame. Chouliara et al. (2014) identifies that shifting shame away from the survivor, and the act of disclosure itself, are instrumental in the recovery process. Moreover, the 'chaining effect' described in Friedman (1994), wherein one disclosure leads to another within a supportive group setting, underscores the potential for sharing of experiences to mitigate the isolating effects of shame.

Yet, the journey towards disclosure is hindered by deep-seated reluctance to discuss the abuse, as reported by survivors of various forms of abuse including clerical abuse in Colarusso (2009) and women who were victims of sex trafficking (Contreras et al., 2017). The internalisation of shame and self-blame delays disclosure makes the process of seeking support much more difficult, as shown in research on North Indian children with CSA histories (Choudhary et al. 2019) and studies by Crisma et al. (2004); this ultimately prolongs the exposure that the survivor has to

their shame, allowing it to further sink into their identity. Socio-cultural dimensions of shame further complicate the disclosure process. For instance, the high value placed on virginity and the general taboo around discussing sex in many cultures, (as found in a study of Puerto Rican women with CSA histories; Fontes, 1993), act as significant barriers to disclosure. Similarly, a study of female Brazilian CSA survivors by Fornari et al. (2018) highlights how these patriarchal societal norms and expectations for women can hinder survivors from coming forward.

Men in particular face unique challenges regarding disclosure, as discussed in the previous section. Studies by Easton et al. (2014) and Gagnier and Collin-Vézina (2016) reveal that not disclosing is often seen as a way to preserve masculinity, with related, overwhelming, guilt preventing disclosure among adult male participants. This is echoed in research on Jamaican men who have sex with men (MSM; Harris & Dunn, 2019), where shame not only acts as a barrier to disclosure but also to reporting abuse to authorities. This reluctance is further exacerbated by fears of authorities' and community members' disbelief and minimization of their experiences (Deering & Mellor, 2011; Hlavka, 2017); although this is a finding common in the accounts of women survivors as well, the likelihood of disbelief in the disclosures of men may be higher than in those of women for the reasons above. In short, whilst shame can be a barrier to disclosure in men, so can the fear of how others may react (Gagnier and Collin-Vézina, 2016).

2.3.5.2.6 Bodily Shame

Shame focused on survivors' physical bodies emerged as a theme broached in several qualitative studies (Colarusso, 2009; Collins et al., 2014; Darlington, 1995; Hodge & Bryant, 2019; Jaswal, 2005; Jung & Steil, 2012; Moulding, 2015; Pettersen, 2013; Singh et al., 2013; Wood & Van Esterik, 2010). Findings from Colarusso's (2009) study of four sisters abused by a priest reveals how shame stemming from CSA can become tied to a desire for bodily autonomy and control, highlighting cases where shame was experienced in situations such as undressing in front of others. The study delves into how bedwetting into adulthood, which may sometimes happen in adult survivors, is

another example of an event in a survivor's life exacerbating the feeling that they lack control of their body.

Bodily shame can manifest in confusing ways, as discussed by Hodge & Bryant (2019) in the context of university women with eating disorders. In their study, shame was not only a byproduct of their experiences of CSA, but also a driving force in how they perceived and treated their bodies. The women's efforts to cope with their bodily shame—through starvation and purging—highlight attempts to regain control and autonomy over their bodies. These behaviours, while harmful in reality, are seen by the women as methods to numb themselves and evacuate the shame attached to their experiences, as if changing their physical appearances might make the shameful parts of their inner selves disappear. This attempt to mask their shame, through the active reshaping of their bodies reflects a deeper issue of disempowerment and a need for self-efficacy. The paradox of shame being both destructive and *seemingly* productive reveals nuances in the ways in which survivors navigate their healing journeys. For some, a manipulation of their physical selves becomes a tangible way to deal with intangible feelings of shame. Yet, this coping mechanism also signifies a struggle to find healthier ways to process and overcome their shame—something that is inherently difficult to do if the shame has prevented them from disclosing the abuse and reaching out for help. Bodily shame is further discussed in Chapter 4 as an important theme in one of the survivor's interviews.

2.3.5.2.7 Guilt and Shame

While the focus of this review is on shame, the related emotion of guilt inevitably and necessarily appears as a focus of some of the studies, as both emotions play off of each other in many cases (Canavan et al., 1992; Choudhary et al., 2019; Collins et al., 2014; Crisma et al., 2004; Darlington, 1995; DiPalma, 1994; Draucker, 1993; Draucker & Petrovic, 1996; Easton et al., 2014; Heiman & Ettin, 2001; Phelan, 1995; Senn et al., 2017).

The interrelation of these emotions within contexts heavily influenced by religious beliefs, underscores the impact these self-conscious emotions have on survivors' recovery abilities. The concept of 'Catholic guilt', mentioned in Colarusso's (2009) study on clerical abuse, exemplifies how religious frameworks intensify feelings of shame and guilt: the sisters in this study, who were abused by a priest, demonstrated shame and guilt so deeply ingrained that they considered themselves sinners for having been abused. This is a clear example of societal factors that exacerbate shame and related reactions—the moral and ethical teachings of their faith directly contributed to these girls' sense of wrongdoing and impurity. Similarly, Collins et al. (2014) found that CSA survivors raised in strict Catholic traditions grappled with pervasive self-blame and guilt, again, thinking of themselves as sinners rather than victims or survivors. The notion of sin and the need for penance, central to many Catholic doctrines, can make it difficult for survivors to disentangle their experiences of abuse from their spiritual beliefs and identities. On a related note, while much of the literature on CSA and religion is focused on Catholicism, it is very likely, given the prevalence of CSA in regions with other dominant religions, that the structures and authoritarian nature inherent to many organised religions lend themselves to similar themes of victim shaming.

DiPalma (1994) offers yet another perspective on guilt, focusing on high-functioning female CSA survivors who felt guilt about not doing enough to stop the abuse. This distinction highlights the nuances of guilt as it relates to survivors' perceptions of their agency and responsibility before, during, and after the abuse. It underscores the psychological burden of feeling powerless to prevent the abuse, coupled with the belief that they should have been able to do more, and self-betrayal from the feeling that their bodies did not do enough to protect them.

The emergence of shame and guilt as separate categories in the study by Draucker (1993) reflects the connection between shame, guilt, and stigmatisation theorised by Finkelhor's

traumagenic model, indicating how shame and guilt responses can mirror the dynamics of stigmatisation by acting as an avenue of self-stigmatisation.

2.3.5.2.8 Self-Blame and Shame

Related to guilt, self-blame emerged as a more minor theme in qualitative studies (Choudhary et al., 2019; Collins et al., 2014; Darlington, 1995; Durham, 2003; McElvaney et al., 2014; Wager, 2015).

The relationship between self-blame and shame is sometimes characterised by an increased sense of responsibility, particularly among children, who may feel compelled to deny or minimise their trauma for the sake of family unity. This compulsion might increase when the perpetrator is a family member, and especially the breadwinner, as highlighted by Choudhary et al. (2019) and in the section on family honour earlier on. The sense of responsibility felt by victims is a common thread in the fabric of self-blame and shame. Durham (2003) observed this phenomenon among adolescent male participants, noting that shame was an integral part of their feeling responsible for the abuse (i.e. shame was an integral part of their self-blame). This suggests that gender norms and societal expectations around masculinity may exacerbate the internalisation of self-blame and shame, and that self-blame seems to be a subcategory of shame. Furthermore, Crisma et al. (2004) and Darlington (1995) both found that survivors often continue to experience self-blame and shame despite intellectually understanding that the blame lies solely with the perpetrator. This dichotomy between cognitive understanding and emotional experience illustrates the complex psychological impact of abuse, where rational knowledge does not necessarily alleviate the emotional burden of guilt and shame—a major theme addressed in survivor interviews in Chapter 4.

2.3.5.2.9 Mitigating Factors for Shame

Preventing and mitigating feelings of shame in survivors involves various supportive strategies that target the roots of shame by promoting self-compassion and resilience. Qualitative research in this area supports the findings of quantitative research, and has identified several key factors that can significantly reduce shame, including participation in support groups, general involvement in the therapeutic process (regardless of the type of therapy), trust-building with clinicians, and positive family responses (Anderson & Hiersteiner, 2008; Ballantine, 2012; Chouliara et al., 2014; Contreras et al., 2017; DiPalma, 1994; Draucker & Petrovic, 1996; Friedman, 1994; Gill & Harrison, 2019; Heiman & Ettin, 2001; Hickie & Roe-Sepowitz, 2014; Jackson, 1994; Lindon & Nourse, 1994; McLean et al., 2018; Newsom & Myers-Bowman, 2017; Teusch, 2001; Zupancic & Kreidler, 1999).

Anderson and Hiersteiner (2008) found that support groups for survivors played a critical role in reducing feelings of shame through acceptance, compassion, and warmth, providing a safe space for survivors to share their experiences and feelings without judgement. The effectiveness of therapy in improving feelings of shame was also highlighted by Ballantine (2012) in the context of sibling incest. This suggests that therapeutic interventions, particularly those that target shame explicitly, and that are compassion-focused, as Chouliara et al. (2014) suggests, can be instrumental in alleviating the unique shame that survivors carry. Therapy offers a structured approach to explore and understand the origins of shame, enabling survivors to process their feelings in a supportive and understanding environment. Trust-building between survivors and clinicians is another crucial factor in decreasing feelings of shame, as found by Contreras (2017) in a study about women survivors of sex trafficking. Establishing a trusting therapeutic relationship can provide the foundation for survivors to open up about their experiences and feelings of shame, leading to a more effective healing process. Supportive comments from peers in group therapy settings, as seen in the study by Hickie and Roe-Sepowitz (2014) serve to reinforce the practice of destigmatisation, and allow survivors to view their experiences from new, non-judgmental perspectives. The facilitators of such groups also play a crucial role in reducing shame

by encouraging open discussion on seemingly taboo and shameful topics and ensuring survivors do not feel isolated.

Another mitigating factor, as seen in the study by DiPalma (1994) on ‘high-functioning’ women survivors of incest, is ‘disrupting’ the linear relationship between abuse severity and negative outcomes through strategies like avoidance and psychological escapes—this is theorised to protect the integrity of the self to some extent, at least in the short term. This approach may also help survivors externalise the blame, attributing it rightfully to the abuser, thus mitigating feelings of shame and guilt.

Draucker and Petrovic (1996) and Gill and Harrison (2019) emphasise the power of vindication of the self and positive family responses to disclosure when it comes to dissipating shame and guilt. When survivors are able to absolve themselves of any wrongdoing and recognize that they deserve to be free of shame, and when families respond positively, offering support and challenging notions of shame around CSA, the healing process is significantly bolstered. These positive reinforcements then help survivors to reframe their experiences and identities.

Finally, another factor involved in the reduction of shame over time, is the transformation of shame and guilt into rage at the perpetrator through extensive therapy, as observed in Heiman’s (2001) study of child survivors (girls) in a therapy group. This marks a significant shift in the emotional landscape of survivors; and perhaps a necessary step in the eventual release of shame, self-blame and guilt. In the case of CSA survivors with an extreme tendency to self-shame and conceal their true feelings even to themselves, the expression of rage is a healthy progression of their process of identity-creation and sense of justice.

2.4 Conclusion

Overall, the review confirms major themes represented in CSA research: , 1) Shame being long-lasting, 2) Shame acting as a mediator between CSA and adverse psychosocial

outcomes, , 3) shame inhibiting disclosure, 4) positive effect of clinical interventions 5) the potential of compassion-focused therapy in reducing shame, , and 6) that the relationship between shame and CSA is influenced by survivor gender.

2.4.1 Conclusions on Quantitative Studies

The 81 quantitative studies included in this review, which involved 26,781 participants, found shame to be a consistent socio-emotional consequence of CSA, interfering with disclosure and linking to a range of poor mental health and social outcomes.

Whilst such findings were emphasised by the vast majority of studies, this perhaps increases the value of studies that failed to find a relation between CSA and elements of shame. For example, Feinauer et al. (2003) found that many survivors did not internalise their CSA-related shame in the long-term, and were able to create meaningful and intimate relationships in adulthood. If this study was not due to a Type II error (failing to reject a null hypothesis that is false), then this raises the question as to what factors led the sample to not internalise shame. To take another example, You et al. (2012) found a relation between shame in CSA survivors and suicidal ideation when such ideation was measured by the Beck Depression Inventory (BDI) but not when measured by the Hamilton Rating Scale for Depression (HAM-D). It may be that important differences between the two scales (the BDI being a self-report scale, while the HAM-D is clinician-administered) resulted in this finding, and more attention may need to be paid to such failures to replicate when designing future research.

It was also clear from this review that there is still much to understand about the relation between shame and CSA. First, the potential for cultural bias in existing quantitative studies appeared very high. As noted, 79 out of the 81 quantitative studies included in the review (i.e., 98% of these studies) were conducted in WEIRD countries . The generalisability of these findings may be questionable. However, studies in non-WEIRD populations did show a number of early

commonalities with the results of studies in WEIRD populations, such as the presence of shame in the wake of CSA and shame as an inhibitor of disclosure.

Second, whilst a number of longitudinal studies were found in this review, it seems clear that there is more need to consider levels of shame over time and factors that promote such change. Third, studies that found different types of shame (bodily, characterological, and behavioural) to be differentially associated with CSA (Milligan & Andrews, 2005; Talmon & Ginzburg, 2017), suggest the need for more fine grained measures of shame with reliable subscales. Fourth, some studies also reported a marked gender difference in levels of post-CSA shame, with girls and women experiencing higher levels of shame than boys and men.

Finally, there appeared to be a need to fit many of these quantitative findings into an overall model. For example, studies showing shame can lead to isolation (Michalopoulos et al., 2015) could be linked to studies showing that shame mediated the relationship between CSA and adult victimisation (Kessler & Bieschke, 1999). Linking such findings into a plausible model of the role of shame in CSA remains an important theoretical task.

2.4.2 Conclusions on Qualitative Studies

As expected, qualitative studies also demonstrated the presence of shame in many survivors, who reported experiencing themselves as bad or defective. The presence of a social stigma, particularly in honour-based communities, was also emphasised. Qualitative work has also helped develop understanding of issues specific to male survivors of CSA, emphasising the experience of a loss of masculinity and how this affects the development of shame. An interesting finding in this regard is that there were several more qualitative studies on male experiences compared to quantitative ones; the reasons behind this would be a useful subtopic to investigate in future research. Similarly, compared to the quantitative research, the set of qualitative studies included more research from non-WEIRD populations. A potential reason for this might be that

qualitative methodologies lend themselves to adaptation to non-WEIRD contexts more than rigid quantitative methodologies such as randomised controlled trials.

As with the quantitative literature, shame was frequently emphasised as a common barrier to disclosure, and the bodily form of shame was often highlighted. Shame was also frequently shown to exist within a nexus of guilt and self-blame. Importantly, the qualitative literature also laid out survivor's insights into what they felt could reduce shame, which included participation in support groups, therapy, trust-building with clinicians, and positive family responses.

2.4.3 Synthesising Quantitative and Qualitative Findings

The qualitative studies reviewed suggest a number of questions that remain to be examined by quantitative methodologies. For example, Heiman and Ettin's (2001) study suggested that shame can be converted into rage at a perpetrator, which may mark progress in the therapeutic healing process. Quantitative work is needed to empirically test this hypothesis, exploring the longitudinal inter-relation between shame and anger-at-perpetrator, and testing how this relates to therapeutically relevant outcomes (e.g., mental health symptomatology).

Likewise the quantitative studies reviewed suggest a number of questions that remain to be examined by qualitative methodologies. For example, Feiring et al.'s (1999) quantitative study recorded a significant reduction in shame levels in girls, but not boys, over the course of one year. Qualitative work should examine how girls and boys experiences of shame in CSA change over time and explore potential drivers of this relation, which could in turn inform the design of further quantitative studies.

One other point of relevance here is that this review found that the mean age of participants in quantitative studies (27.4 years) was markedly lower than that of qualitative studies (33.7 years). The factors driving this need to be better understood. It could be speculated

that research tends to view older survivors as better emotionally placed to communicate their experiences in qualitative interviews, or that volunteers for such research tend to be older.

2.4.4 *Limitations of this Review*

2.4.4.1 Measurement Issues

This review found that studies of shame in CSA used a wide-variety of shame measurement methods. This indicates a clear lack of standardisation and consensus in how shame not just in CSA survivors, but in the aftermath of abuse in general, should be quantitatively measured. The shame scales in existing CSA literature are generalised to many types of abuse, which ultimately obscures the particularities of CSA-related shame and shame stemming from other forms of abuse. There is also a noticeable lack of clinically-administered and multi-modal methods of shame assessment, signalling an opportunity for their development. Furthermore, only two studies used measurements of shame based on objective facial responses, rather than self-report questionnaires (Bonanno et al., 2002, 2003; Negrao et al., 2005). Yet it appears inappropriate to view measures of shame based on facial responses as an ‘objective’ measure of shame that self-report measures should strongly correlate with in order to prove the validity of self-report measures. As Negrao et al. (2005) found, the relation between facial shame and mental health difficulties was influenced by whether verbal humiliation was also present. An important question for future work is what situations lead shame to manifest facially in CSA survivors and what predictive power such shame has in relation to mental health difficulties.

The paucity of non-WEIRD studies found by this review also suggests that there is likely to be a strong cultural bias in existing questionnaires, which may fail to measure signs or experiences associated with shame in many non-WEIRD countries or in minorities within WEIRD countries. This issue will be explored further in Chapter 4.

More generally, further work is needed into the multiple ways in which shame can be assessed in CSA survivors in order to determine what the most reliable and valid measures are. For example, future longitudinal work into changes in shame over the course of compassion-focussed therapy could include both self-report, clinician-report and facial measures of shame, to examine the interrelation between these measures and their (co-)movement over time. Such work would help provide the field with a gold standard measure going forward, which would support future meta-analytic work.

2.4.4.2 Publication Bias

As with any review, the potential issue of publication bias (i.e. the results of published studies being systematically different from those of unpublished studies) needs to be considered. Publication bias is perhaps more of a concern in this area of inquiry than others. Famously, a meta-analysis by Rind et al. (1998) reported a lack of association between CSA and negative outcomes, creating a firestorm of political and scientific outrage (Lilienfeld, 2002). One can hence imagine pressures existing that would discourage researchers to publish null results in this field. As this review did not include a meta-analysis, it is not in a position to use tools such as funnel plots to assess if publication bias is likely to have been present (Harbord et al., 2006). Whilst publication bias cannot be ruled out in the current review, it can nonetheless be noted that studies were found which failed to report effects reported by the majority of studies (e.g., Ellenbogen, 2018; Feiring, 2010). As emphasised above, there is the need to further consider the results of such studies to see if they can shed light on why widely reported effects were not found, rather than simply writing them off as Type II errors.

2.4.4.3 Quality Assessment

In the pre-registered protocol for this review, it was stated that the review would assess the quality of included studies using the Mixed Methods Appraisal Tool (MMAT; Hong et al., 2018).

The MMAT was designed for the critical appraisal of empirical studies of various designs in systematic reviews. Unfortunately, due to the unexpectedly large number of studies included in the review, there was a lack of resources to perform this quality assessment. There is hence a need for a future review to consider the quality of studies in this area and to prioritise evidence by quality.

2.4.5 *Gaps in Shame and CSA Research*

Although the body of research assessed in this review offers a breadth and depth of both quantitative and qualitative data that progresses our knowledge of how shame operates in the context of CSA, there remain gaps in terms of some of the specific methodologies and topics that still need to be researched, as well as a general lack of studies dedicated to CSA shame alone (both quantitative and qualitative).

2.4.5.1 Need for More Longitudinal, RCT Research

In order to develop more effective interventions for reducing shame, robust randomised controlled trials and longitudinal studies must be conducted in the field. As it is clear that shame is implicated in so many of the negative sequelae in the aftermath of CSA, longitudinal studies will offer insights into the lasting impacts of interventions, capturing the evolution of survivors' experiences with shame over time, and what factors may help or hinder the trajectory of healing. There is however, a need to couple such work with qualitative studies attempting to understand this process of change. This combination of methodologies is ultimately needed to develop evidence-based strategies that are both effective and culturally/contextually adaptable, and to move from less appropriate approaches (which were perhaps not created for CSA survivors, but for victims of other types of trauma, for instance), to on-the-ground solutions that enhance survivors' long-term recovery and quality of life.

2.4.5.2 Need for Meta-Analysis of Shame Measures

A meta-analysis of measures of shame in relation to CSA survivors is needed to complement this systematic review. Precise measurement tools are necessary for accurately assessing the extent and nuances of shame before, during, and after clinical interventions, and for allowing researchers to identify the most affected areas of a survivor's life. However, a meta-analysis of measures of (trauma-related) shame in the context of CSA is yet to be done, and time constraints prevented it from being conducted as part of this project. A meta-analysis extending the findings of this PhD project would aid clinicians and researchers alike in determining how suitable existing tools of measuring shame are for the CSA survivor population (and whether new tools, or an amalgamation of the existing tools, must be created).

2.4.5.5 Behavioural Measures of Shame

Expanding the research on behavioural measures of shame (such as the Facial Action Coding System; Ekman & Friesen, 1976) in CSA survivors is needed to better assess survivors' behavioural indicators, such as avoidance (in a variety of contexts, including avoiding discussion of the abuse with the therapist), social withdrawal, aggression, or people-pleasing, as an additional measure of shame. Behavioural measures can also reveal the presence and intensity of shame in ways that self-report measures cannot capture. This approach enables the development of interventions that are directly responsive to observable signs of distress, facilitating targeted support that addresses both the psychological and behavioural aspects of shame. By integrating behavioural measures with self-report measures of shame, service providers can develop a more rounded longitudinal assessment for shame, one that can help particularly in cases where survivors change therapists.

2.4.6 Next Steps

The findings of this extensive review have revealed an urgent need to evaluate existing measures of trauma-related shame in the CSA context, and in relation to other common outcomes identified

here. This will be conducted in the next chapter. In addition, as shame-targeted qualitative research has also been identified as a need, Chapter 4 will use in-depth interviews with survivors and service providers to delve into the specificities of CSA shame from both perspectives.

Chapter 3: Quantitative Evaluation of Trauma-Related Shame in the Context of CSA

3.1 Introduction

3.1.1 Background

Chapter 2 has laid bare the deep-rooted sense of shame that commonly results from CSA, and the feelings of self-blame, humiliation, worthlessness, and a distorted, negative sense of self that are consequently engendered in survivors. The findings of the chapter highlight the need for accurate detection, measurement, and treatment of CSA-related shame in order to understand the psychological and emotional experiences of survivors and offer effective therapeutic support. As part of this, there is a better need to understand the mechanisms through which such shame arises.

As was also shown in Chapter 2, one element of CSA-related shame that remains poorly understood is what factors mediate or moderate the relation between CSA and CSA-related shame. A recent scoping review evidenced that it is well-established that the severity of PTSD (in general, not specific to CSA) is positively related to levels of shame (Saraiya & Lopez-Castro, 2016). As detailed in Chapter 2, studies have consistently shown that CSA survivors are at a significantly elevated risk of developing PTSD. Symptoms such as intrusive memories, nightmares, hypervigilance, and emotional numbing often accompany the shame experienced by survivors; furthermore, problems with memory recollection may exacerbate survivors' self-doubt, thereby contributing further to shame (Alix et al., 2017; Dorahy et al., 2016; Ellenbogen et al., 2018; Feiring et al., 2002; Jung & Steil, 2012; Lindberg & Distad, 1985; Michalopoulos et al., 2015). The traumatic memories associated with CSA can evoke feelings of intense self-blame, worthlessness, and disgust, which serve as powerful triggers for PTSD symptoms. However, it remains poorly understood what mediates the relation between PTSD and CSA-related shame.

3.1.2 Models to be Tested

The first aim of the current study was to test the hypothesis that the severity of PTSD symptomatology would be positively associated with levels of CSA-related shame in survivors of

CSA. The second aim of this study was to test for potential mediators and moderators of this hypothesised relation between PTSD symptom severity and CSA-related shame in survivors of CSA. Based on the work discussed in Chapters 1 and 2, levels of self-compassion have the potential to act as such a moderator or mediator (Anderson & Hiersteiner, 2008; Bowyer et al., 2014; Chouliara et al., 2011; Hamrick & Owens, 2019; McLean et al., 2018, 2018). We have already seen how a potential route towards healing and recovery in CSA survivors may involve self-compassion-focused therapeutic approaches. One of the reasons self-compassion may be seen as an important way forward, is that it is in many ways the opposite of shame. The core tenets of self-compassionate practice, as operationalised by compassion-focused therapy (CFT; Gilbert, 2009; Neff, 2003) involve developing the following skills: care for one's wellbeing, sensitivity and softness towards the self, distress tolerance, empathy, and non-judgement. Moreover, self-compassion, and in particular compassion-focussed therapy (CFT), has been associated to some extent with improved general mental health outcomes, including reduced symptoms of depression, anxiety and PTSD (Egan et al., 2022; López et al., 2018; Pullmer et al., 2019; Wilson et al., 2019; Winders et al., 2020). CFT helps survivors build a kinder relationship with themselves, by providing a structured framework for helping survivors challenge and change their negative self-perceptions into self-compassion.

Understanding the role of self-compassion in the process of mitigating severity of these symptoms should be the next step in CSA and shame research. The current study hence set out to test a model in which self-compassion levels moderate the relation between PTSD severity and CSA-related shame (Model 1) and another model in which self-compassion levels mediate the relation between PTSD severity and CSA-related shame (Model 2). The reason both models were tested is that it was unclear whether self-compassion would explain the process through which PTSD severity and CSA-related shame were associated, with self-compassion being reduced by PTSD symptomatology and thereby increasing CSA-related shame (i.e., a mediation relation) or

whether self-compassion levels would influence the strength of relation between PTSD severity and CSA-related shame.

Another hypothesis that was to be tested as part of this study was the size of the relation between CSA-related shame and more general trait levels of shame. Trait shame or general shame, as it will be referred to in this study, is the disposition to emotionally respond to situations, such as making a mistake, failing at a task, or violating social norms, with the experience of shame (as explained in Chapter 1). In fact it may be argued that general shame occasioned by such situations has a role to play in developing a social and moral compass, often enabling and encouraging individuals to engage in prosocial behaviour. Usually, general shame is situational and transient, and fades away with time as individuals reflect on the experience, learn from their mistakes and move on. General shame, while it can be uncomfortable and distressing, typically does not cause the individual to carry the same level of profound self-blame and self-disgust as CSA related shame. An additional important aspect is that general shame is usually recognised and accepted by society, making it much easier to reach out for support and understanding. Hence, assessing general shame in conjunction with CSA-related shame is useful in parsing out the differing dynamics of each outcome. This study will look at the relationship between the two types of shame as well as how both types of shame are (potentially differentially) related to other study measures.

In terms of these other study measures, another measure which was of interest was levels of guilt. The concept of guilt often appears in literature on shame (and CSA-related shame specifically; see Chapter 2). Unlike shame however, guilt arises from the belief that one has committed a moral or ethical transgression; while guilt may be focused on (lack of certain) actions or perceived failures, shame is more concerned with the self as a whole (Tangney, 1998). In the context of CSA, survivors frequently grapple with guilt as they may wrongly perceive themselves as complicit in the abuse or feel responsible for not preventing it (Dorahy & Clearwater, 2012; Ginzburg et al., 2009; Stuewig & McCloskey, 2005; Tangney, 1998; Woien et al., 2003). In non-

abuse-related contexts, guilt might serve as a powerful motivator for taking responsibility and making amends— but in the context of someone who has experienced CSA, it can significantly intensify psychological distress and impair well-being. The current study hence aimed to examine relations between shame and guilt, as well as how shame and guilt (again potentially differentially) related to other study outcomes measures, such as depression levels.

Depression was another factor of interest for this study because it is an extremely common long-term outcome in survivors, and may have a significant relationship with shame. Previous studies, as outlined in Chapter 2, have shown a strong, almost inevitable link between CSA and depression (Åslund et al., 2007; Chang et al., 2018; Egan et al., 2022; MacGinley et al., 2019; Newman et al., 2000; Saraiya & Lopez-Castro, 2016; Yaroslavsky et al., 2022). Furthermore, understanding the interplay between depression, shame, and the other outcomes of interest is crucial for several reasons. First, considering that Major Depressive Disorder has generally been comorbid with experiences of several types of abuse, confirming the existence of this relationship in the presence of shame, and exploring the potential pathways from CSA-to-depression-to other outcomes in which shame may play a role, would be a first step in developing a potentially new target for mitigation of depression symptoms. In terms of this study, it was hypothesised that there would be a positive correlation between levels of CSA-related shame and depression; a model will be tested in which self-compassion potentially moderates this hypothesised relation between CSA-related shame and depression (Model 3). A mediation model with these factors was not deemed necessary to test however, as there seems to be ample evidence that the relationship between shame in the aftermath of CSA and depression exists in most cases of CSA, and that therefore its existence is not dependent on the presence of a certain level of self-compassion in survivors.

A final aim of the present study was to test the relation between time spent by participants in psychotherapy and levels of CSA-related shame. Research has shown that depending on type and intensity of the therapy, longer engagement with psychotherapy services

can be associated with better mental health outcomes, though short-term therapies of high intensity can sometimes be more beneficial (Knekt et al., 2016; Kreidler & Einsporn, 2012; Nordmo et al., 2020). Given the developmental trauma of CSA, and how integrated shame likely is in survivors' sense of self, it was hypothesised that there would be a negative correlation between time spent in therapy and CSA-related shame.

These hypotheses and models were to be tested in three specific populations in Ireland; clients of a psychotherapy clinic for CSA survivors; a service for migrant women; and members of online CSA survivor support groups on Facebook. The reasons for the choice of these groups is discussed in Section 3.2.3 below.

3.2 Method

3.2.1 Selection of Measurement Tools for Shame and Other Outcomes

Measurement tools used to measure the outcomes described above were in part informed by the results of the systematic review conducted in Chapter 2, and in part on the tools used in Øktedalen et al.'s (2014) original psychometric evaluation of the Trauma-Related Shame Inventory.

3.2.2 Reliability and Validity of Measures in the Questionnaire

3.2.2.1 Trauma-Related Shame Inventory (TRSI). In the broader context of trauma research, some measurement tools and scales have been developed to assess the experience of shame in the context of trauma; these were discussed in Chapter 2. These instruments aim to provide researchers and clinicians with a structured and standardised means of evaluating the intensity, duration, and impact of shame in trauma survivors. The most employed methods include self-report questionnaires and clinical assessments. The Trauma-Related Shame Inventory (Appendix H) is a relatively new 24-item self-report scale developed by Øktedalen et al., (2014) to measure a respondent's state-level shame in relation to a traumatic event in their life. For this scale, trauma-related shame is defined as *"a negative evaluation of the self in the context of trauma with a painful affective experience, and a behavioral tendency to hide and withdraw from others to conceal one's own perceived deficiencies."* (Øktedalen et al., 2014, p. 5).

Items on the scale attempt to measure negative appraisals of the self, which in turn include sub-constructs of internalised and externalised shame, affective, and action tendencies related to shame. Items are rated on a 4-point Likert scale based on the presence of the feelings/actions described in the item within the last seven days (0=not at all correct about me; 1=sometimes correct about me; 2=mostly correct about me; 3=completely correct about me). An overall score of trauma-related shame is calculated by summing the scores of all items. Øktedalen et al. (2014) conducted a psychometric evaluation of this scale using univariate and multivariate generalisability analysis based on G-theory (generalisability theory; Cronbach et al., 1972) and found acceptable levels of validity and reliability of this scale in a clinical population (people with diagnosed PTSD): the composite G-coefficient score was 0.87, and the index of dependability for measurement design was also 0.87 – these are both types of construct reliability measures within G-theory. They also concluded that the scale is sensitive enough to capture variability between individuals when it comes to shame-related behaviours, without being influenced by other sources of variance. The Cronbach's alpha of the TRSI in this study is 0.96 (N=47).

3.2.2.2 Test of Self-Conscious Affect-3 (TOCSA-3; Shame Items). The Test of Self-Conscious Affect (Tangney et al., 1989; Appendix H) is one of the most widely-used measures of shame and guilt in research, consisting of subscales measuring shame-proneness, guilt-proneness, externalisation of blame, detachment unconcern, pride in self, and pride in behaviour. The long-form version of the TOCSA-3 has 16 items across all the subscales. Each item presents a hypothetical everyday scenario, and offers five potential reactions (each corresponding to one of the five subscales above), which respondents must rate on a five-point Likert scale (1=reaction is not likely; 5=reaction is very likely). Due to its focus on shame-proneness in scenarios not related to a particular (traumatic) event, but rather on day-to-day reactions, the TOCSA is considered to be a measure of trait-level general shame, or shame-proneness. As this study was concerned with comparing and correlating shame measured by two different tools, only the response items

measuring shame-proneness were used rather than all five response options. This decision also aided the study by making the survey much shorter and therefore easier to complete.

Adequate validity and reliability have been found in several studies using the TOSCA-3 in different populations, such as in Woien et al., (2003), which reported an internal consistency score of $\alpha = .77$ for the shame-proneness subscale. In this study, a Cronbach's alpha of 0.79 (N=52) was found, indicating adequate internal consistency of shame-proneness items. While the TOSCA-3 was not used in Øktedalen et al. (2014), it was deemed a worthwhile scale to include in this study due to its popularity in shame research, and its divergence from the TRSI (in its measurement of general, rather than CSA shame).

3.2.2.3 Trauma-Related Guilt Inventory (TRGI)

The Trauma-Related Guilt Inventory (Kubany et al., 1996; Appendix H) is a 32-item self-report scale assessing feelings of guilt relating to trauma. Respondents are asked to think back to a traumatic event and rate how applicable certain emotions and thoughts are in relation to that event, on a five-point Likert scale (1=not at all true; 5=extremely true). The scale consists of the following subscales: global guilt, distress, hindsight-bias/responsibility, wrongdoing, and lack of justification. The last three subscales are grouped under the construct 'guilt cognitions'; a total score for the entire measure is not recommended, but rather total scores for the subscales 'global guilt', 'distress', and 'guilt cognitions' are calculated via summing the items corresponding to each subscale (some items must be reverse-coded). Kubany et al. (1996) showed adequate internal consistency (Cronbach's alpha= 0.86), and correlations with depression and PTSD in a sample of people with trauma histories. It is also used in Øktedalen et al. (2014). In this study, the TRGI showed a Cronbach's alpha of 0.89 (N=24), indicating adequate internal consistency of items.

3.2.2.4 Impact of Events Scale-Revised (IES-R). The Impact of Events Scale-Revised (Weiss, 2007; Appendix H) is a widely-used self-report measure of the severity of an individual's PTSD symptoms (based on DSM criteria). It consists of 22 items describing thoughts and feelings relating to a traumatic event, that correspond to the PTSD symptom categories of intrusion,

avoidance, and hyperarousal. Respondents are asked to rate how distressed or bothered by the thoughts/feelings they have been in the past seven days, on a five-point Likert scale (0=not at all; 1=a little bit; 2=moderately; 3=quite a bit; 4=extremely). This particular measure of PTSD was chosen based on its relatively short length and straightforwardness, as well as its relatively wide use in research. The IES-R has been translated into and validated in several languages. Internal consistency for the IES-R is generally high; Creamer et al., (2003) reported a Cronbach's alpha of 0.96, and Beck et al., (2008) found adequate validity for its three-factor structure. In this study, the Cronbach's alpha for the IES-R is 0.96 (N=40), indicating high internal consistency and reflecting the results of Creamer et al., (2003) and Beck et al., (2008).

3.2.2.5 Beck Depression Inventory (BDI-II). The Beck Depression Inventory (Beck et al., 1996; Appendix H) is a 21-item self-report scale measuring the following symptom categories of depression (based on DSM criteria): cognitive, affective, motivational, and physiological symptoms. Respondents are asked to rate the severity of the symptom described on a 4-point Likert scale, based on how they have felt for the past seven days (0= least severe/symptom not present; 3= most severe/symptom present almost all of the time). The BDI-II has been validated many times for use as a clinical and research tool, and is currently one of the most widely used self-report scales for depression. The Cronbach's alpha for the BDI-II in this study is 0.91 (N=38). A total score of depression severity is calculated by summing the score of each item. The scale was also used by Økstedalen et al. (2014).

3.2.2.6 Self-Compassion Scale (SCS). The Self-Compassion Scale (Neff, 2003; Appendix H) is a 26-item self-report tool measuring the degree of self-compassion the respondent is capable of during emotionally distressing periods of time. The scale addressed the following constructs: kindness towards the self, self-judgement, common humanity, isolation, mindfulness, and over-identification. Respondents are asked to rate how often they would typically act toward themselves in the way indicated in the item, on a 5-point Likert scale (1=almost never; 5=almost always). Items worded to address negative feelings are reverse-coded. A total self-compassion

score is calculated by summing the scores of each item (once relevant items are reverse-coded). In Neff's original psychometric evaluation of the SCS, a six-factor model (comprising the six sub-constructs mentioned above) was found to have adequate validity in a confirmatory factor analysis (comparative fit index [CFI]=0.91), and a single higher-order factor of self-compassion was also found to fit the data well (CFI=0.90). In this study, the SCS showed a Cronbach's alpha of 0.90 (N=43), indicating high internal consistency between items. The scale was also used by Økstedalen et al. (2014).

3.2.3 Ethics, Recruitment, and Data Collection Procedures

Ensuring proper psychological safeguards, ethics procedures, and data protection was paramount for this study given the sensitive nature of the topic, and the vulnerability of the population being recruited. These processes are detailed below. Given the resource and time constraints of the PhD programme, the scope of recruitment was limited to sites to which either the lead researcher or her supervisors already had some sort of link.

In order to provide maximum safeguarding of participants, we aimed to recruit participants who were already in contact with psychological support services. This meant that should any distress occur to participants, then support would already be in place.

Ethical approval for this study as a whole was granted on June 28th, 2021 by the Faculty of Health Sciences Level II Research Ethics Committee in the School of Medicine, Trinity College Dublin. On examination of the ethics application, and on account of the anonymous nature of the data collection process (in which no personal or identifiable data would be collected), a Data Protection Impact Assessment was not deemed necessary to conduct by the ethics committee; standard GDPR guidelines were followed throughout. Surveys were conducted on Qualtrics online survey software.

Participants were recruited from three sites, described below. The general process of recruitment/participation in surveys was generally the same for all three recruitment sites (any differences are highlighted in their respective sections). Consent forms, participation information

leaflets, invitation emails, and online posts (where applicable) used in this study can be found in Appendices F-I.

3.2.3.1 Recruitment Site 1: Psychotherapy Clinic

The original site of recruitment was a psychotherapy clinic whose clientele includes survivors of CSA. Ethical approval was initially granted for data collection at the clinic; the two subsequent sites of recruitment were then approved under the umbrella of this site, as amendments to the original study.

Initial contact was made with the clinical director of the service, who then acted as a gatekeeper between the researchers and the participants throughout the study – at no point did any of the researchers have any contact with participants, either in person or online. This was done to avoid any undue pressure to participate that might result from meeting/connecting with the researchers in person.

The lead researcher then designed and presented a draft of the survey to the clinical director, who provided feedback regarding adjustments and deletions of scales to suit the clinic's clientele. A distress protocol was also designed in collaboration with the clinic to ensure participants were signposted to appropriate help in case of distress (please see Appendix G for a description of the protocol).

Once the survey design, invitation email, and recruitment process was finalised, the ethics application was submitted along with a letter of support from the clinic. Upon ethical approval of the study, the clinical director emailed clients they thought were in a position to respond to the survey with an invitation email asking them to consider responding to the survey. It is important to note that (following the approved ethics protocol), the survey link was *not* sent to potential participants in this original email – rather they were given seven days to think about whether they would like to participate, after which a subsequent email was sent to them by the clinical director with the link to the survey. Informed consent was recorded at the start of the survey through a

series of questions ensuring that the participant had read and understood the information presented to them at the beginning.

Several months after the first round of recruitment through the clinic, it was decided that a second round of recruitment needed to be done to increase the sample size of the study. Unlike in the first round, participants were not recruited via email this time, but rather the link to the survey was posted on the clinic's website. Some additional suitable clients were also emailed by the clinical director to gauge interest.

3.2.3.2 Recruitment Site 2: Facebook Support Groups for CSA Survivors

Ethical approval for the study amendments to recruit from Facebook support groups was granted on January 27th. Recruitment through social media sites was considered as a next step in data collection, as the sample size gained through clinic recruitment was still quite small. While ultimately it was deemed that sharing the survey openly via multiple avenues of social media would likely not be given ethical approval (due to the risk of causing distress to survivors who may not have adequate mental health supports in place), the researchers decided to consult a survivor-researcher in order to find out if there were specific, safer modes of social media through which the survey could be shared. This consultation resulted in utilising closed Facebook support groups for CSA survivors to share the survey.

These groups were chosen because they were not open to the general public, and, according to the survivor-researcher consultant, comprised mostly of survivors who had at some point engaged in therapy or counselling about their abuse. This seemed to reduce the likelihood that respondents from this pool would experience distress while completing the survey, as participants would generally be used to discussing various aspects of their abuse. Furthermore, the survivor-researcher herself was a member of several of these groups, which meant that she could act as a gatekeeper between the researchers and participants.

Once an ethical amendment had been granted to recruit from these support groups, the lead researcher created a draft post to publish in the groups (Appendix D), with information about

the survey, the survey link, and disclaimers to prevent distress in participants. The survivor-researcher, now acting as gatekeeper, approved the draft, and proceeded to publish this post, along with an attachment of the Participant Information Leaflet, to a handful of support groups of which she was a member. Over the course of three-four months, the survey was posted in these groups several times. At no point did the researchers have any contact with the participant pool.

3.2.3.3 Recruitment Site 3: Migrant Women's Support Service

The final recruitment site was granted ethical approval on July 7th, 2023. A service, based in Ireland, that supports migrant women was chosen as a recruitment site. This service engages with migrant women around Ireland; though these women hail from all over the world, the service's clients include asylum seekers and refugees from sub-Saharan Africa, North Africa, and the Middle East.

Once an ethical amendment to add this recruitment site was granted, three staff members (not including the lead researcher) who worked directly with clients were designated as gatekeepers who shared messages over WhatsApp, as well as emails, with clients informing them of the survey. Unlike with the psychological clinic, a seven-day waiting period before sending the survey link was deemed not necessary by the ethics committee. A poster (Appendix I) informing clients about the survey was also posted in the service's office.

3.2.3.4 Lessons Learned from Unsuccessful Recruitment

One important recruitment site considered was a local regional mental health department of the Health Service Executive (HSE). Had approval been gained from this initial site, then approval could have, in theory, been gained in a shorter period of time at all other HSE regions. The Clinical Lead of this targeted region was contacted and the study aims explained. Their team agreed to support the work of this project with their clients. An ethical application was made to the HSE, supported by this region, which was reviewed by the HSE Human Research Ethics Committee. The committee requested minor clarifications, which were readily addressable, but unfortunately the Clinical Lead at the site now no longer felt his team had the resources to pursue the project due to the service

undergoing a restructuring at the same time. This meant an application would have had to be resubmitted via another HSE site, which time did not permit. The lesson learned from this process was that any future project should target multiple HSE regions simultaneously where the project is on a tight timescale.

3.2.4 Statistical Analysis Strategy

At the beginning of the larger PhD project, the intention of the quantitative portion was to conduct a psychometric evaluation of the TRSI. However, once recruitment for the survey began, it was apparent that the sample size required for a confirmatory (or even exploratory) factor analysis would not be achieved. This resulted in an adjustment of the original aims, to the aims that are described above.

As a first step, relationships between outcome measures, and time spent in therapy, are considered via Pearson correlations (Table 2). Next, potential mediating and moderating relationships were tested through three ordinary least squares (OLS) multiple regressions. The first two regressions included two predictors and one dependent variable, with $n=39$. The final regression included two predictors and one dependent variable, with $n=37$. An *a priori* power analysis was conducted using G*Power (Faul et al., 2007, 2009) to determine the minimum sample size required to detect a large effect size. Results of the power analysis indicated that for a fixed model linear multiple regression with two predictors, a desired power of 0.80, a desired large effect size ($f^2=0.35$), and at a significance criterion of $\alpha=0.05$, a minimum of $n=31$ was needed. Thus, the obtained sample sizes of $n=39$ (models 1 and 2) and $n=37$ (model 3) are adequate to detect large effect sizes and test the relevant hypotheses.

All scales were mean-centred prior to conducting the regressions. Descriptive statistics and normality tests are also described below (Table 1, Figure 3.1). Between-group analyses were ultimately not conducted due to the small sample sizes of each recruitment site's pool. All statistical analyses were conducted in IBM SPSS Statistics (Version 29) (*IBM SPSS Statistics for*

Windows, Version 29, 2-22). Regression analyses were conducted using the PROCESS Macro extension on SPSS (Hayes, 2022).

Throughout the thesis, and particularly in this chapter, the terms ‘direct’ and ‘indirect’ effect are used to refer to the results of the multiple regressions that were conducted. These are the standard statistical terms used when describing the raw results of regressions– ‘direct effect’ refers to a potentially significant relationship between the two main variables being tested (i.e. PTSD and CSA shame), while ‘indirect effect’ refers to a potentially significant relationship involving a mediating or moderating variable (i.e. self-compassion as a moderator). It is important to note that these terms do not signify or imply a causal relationship.

3.3 Results

3.3.1 Demographics

The total number of people who filled out a significant portion of the questionnaire is 52 (referred to as total participants); out of these, 37 completed the questionnaire until the end (completers). An additional number of people started the survey (39 people), but did not get past the first few questions; these participants were removed from the dataset. Thirty-five (67.4%) of the total participants (i.e. participants in the final dataset) were recruited from the psychological clinic, 14 (26.9%) from the CSA support Facebook groups, and three (5.8%) from the service supporting migrant women. In terms of gender balance, 41 of total participants (78.8%) identified as women, 7 (13.5%) identified as men, and 3 (5.8%) identified as non-binary, reflecting general trends of participation in research about sexual abuse (one participant preferred not to share their gender). The mean age of total participants, based on the 46 respondents who provided their age, is 42.3 (SD=14) years.

The average period of time respondents had engaged in therapy is 24.8 months (SD=40). A small number of participants, six, had never engaged with therapy at time of participation. Out of the 17 participants who were asked about engaging in therapy in their childhood (as the necessity of this question was only realised towards the end of the study) 14 (82.4%) indicated

having engaged in therapy in their childhood. In terms of perpetrator profile, 27 respondents indicated that their perpetrator was someone within their household; 16 said their perpetrator was someone in their wider family, and 29 reported that their perpetrator was someone outside of their family (known or unknown). For this question, participants could choose more than one option; out of the 50 people who responded to this question, 14 (28%) selected multiple options, likely (but not definitively) indicating that they were abused by more than one perpetrator. More specificity about perpetrator characteristics was not drawn out in order to avoid collecting potentially identifiable information.

Due to the length of the survey, and because all questions were made optional as per ethical guidelines, the number of participants who responded to each question differed, sometimes greatly. In particular, participant dropoff predictably increased towards the middle and end of the survey (hence the difference in partial and complete survey responses); however, some participants may also not have felt comfortable responding to certain demographic questions, for instance, or to specific, potentially triggering questions in other scales. Taking this into account, the statistical analyses below indicate the number of participants (N) who fully completed the scale or scales being used in that particular analysis. For example, in Table 3.1 the mean TRSI score is calculated using the 47 participants with complete responses to that particular scale (incomplete responses were not analysed); on a similar note, the correlation between TRSI scores and SCS scores was calculated using the data of the 42 participants who completed *both* those scales (i.e. incomplete responses on either scale were not included in the correlation analysis).

3.3.2 Descriptive Statistics and Tests of Normality for Outcome Measure Scores

The means, standard deviations, and ranges of the scores of each outcome measure are presented in Table 3.1. Analyses of normality were carried out before conducting correlational and regression analyses. As seen in Table 3.1, skewness and kurtosis of all scales fell within the boundaries of normality ($z < 1.96$ for small samples; (Kim, 2013). Additionally, Q-Q plots (Appendix J) were created for each outcome measure to visualise the distribution of the scores. All plots

showed a fairly normal distribution (Yearsley, 2024). Finally, Little’s MCAR test (missing completely at random; Little, 1988) was conducted to ensure that data were not missing due to errors in administration of the survey, survey design, or other factors. The MCAR test resulted in a chi-square statistic of 25.9 (df=22, p=0.26); the non-significance of the statistic indicates that any missing data were missing completely at random. Based on this assumption, where fewer than four item responses were missing from cases, data were imputed based on the average rating of that particular scale item among the other respondents.

Table 3.1
Descriptive Statistics

	N	Range	Mean	Standard Deviation	Skewness		Kurtosis	
					Z statistic	Std. Error	Z statistic	Std. Error
TOSCA-3 (shame items)	52	28.00-80.00	59.58	10.47	-0.90	0.33	1.25	0.65
TRSI	47	24.00-96.00	66.40	19.32	-0.60	0.35	-0.09	0.68
SCS	43	26.00-93.00	59.58	17.34	0.01	0.36	-0.92	0.71
IES-Revised	40	22.00-110.00	73.15	23.31	-0.49	0.37	-0.63	0.73
BDI-II	38	21.00-77.00	51.13	15.47	-0.21	0.38	-0.93	0.75
TRGI Global Guilt Subscale	24	1.00-5.00	2.99	1.36	-0.29	0.47	-1.05	0.92
TRGI Distress Subscale	24	1.00-5.00	3.72	1.31	-0.90	0.47	-0.40	0.92
TRGI Guilt Cognitions Subscale	24	1.32-4.18	2.26	0.68	1.05	0.47	1.60	0.92

Note. N refers to the number of participants who filled out all items on the indicated scale. Descriptive statistics were only calculated for cases where all items of a scale were filled out.

Note. A total score comprising all items is not calculated for the TRGI—rather three subscale scores are calculated instead.

Note. TOSCA: Test of Self Conscious Affect; TRSI: Trauma-Related Shame Inventory; SCS: Self-Compassion Scale; IES-Revised: Impact of Events Scale-Revised; BDI-II: Beck Depression Inventory 2nd Edition; TRGI: Trauma-Related Guilt Inventory

3.3.3 Bivariate Correlational Analyses

To address Aim 1, bivariate Pearson correlations were examined between the total scores/subscale scores of all scales (Table 3.2). Time in therapy was a demographic variable of interest that was added to the matrix. All correlations reported are two-tailed.

Due to the number of correlational tests performed (36), some correction to alpha was required to account for the increased likelihood of a Type 1 error (finding an effect where none was actually present). However, due to the already low small sample size, a Bonferroni correction

was felt to be too severe and likely to lead to an unacceptably high risk of Type II errors (failing to find an effect when an effect is actually present). In order to try and balance concerns over Type I and Type II errors, alpha was set at $p=.01$.

As Table 3.2 shows, bivariate correlations with a significance of $p=0.01$ and below were found between the following outcome measures: TOSCA-3 and TRSI (positive correlation; $N=47$, $r=0.41$, $p=0.004$), TOSCA-3 and SCS (negative correlation; $N=43$, $r=-0.457$, $p=0.002$); TRSI and IES-R (positive correlation; $N=39$, $r=0.58$, $p=0.000$); BDI-II and SCS (negative correlation; $N=37$, $r=-0.592$, $p=0.000$), BDI-II and IES-R (positive correlation; $N=37$, $r=0.529$, $p=0.001$), BDI-II and TRGI Distress Subscale (positive correlation; $N=24$, $r=0.68$, $p=0.000$); and TRGI Guilt Cognitions Subscale and TRGI Global Guilt Subscale (positive correlation; $N=24$, $r=0.578$, $p=0.003$). There was hence robust evidence of positive associations between general shame and CSA shame.

Due to concerns over Type II errors, correlations with a significance between $p=0.05$ and $p=0.01$ are also highlighted here. Such correlations were found between the following outcome measures: TRSI and SCS (negative correlation; $N=43$, $r=-0.343$, $p=0.03$), TRSI and BDI-II (positive correlation; $N=37$, $r=0.403$, $p=0.012$); TRGI Distress Subscale and SCS (negative correlation; $N=24$, $r=-0.507$, $p=0.012$), and TRGI Distress Subscale and IES-R (positive correlation; $N=24$, $r=0.464$, $p=0.02$).

Surprisingly, no significant correlations were found between time in therapy and any outcome measures, or between the TRGI and the TRSI or TOSCA-3.

Table 3.2
Bivariate Correlations

Outcome Measure		1	2	3	4	5	6	7	8	9
1. TOSCA-3 (shame items)	Correlation (<i>r</i>)	1								
	P-value (2-tailed)	–								
	N	52								
2. TRSI	Correlation (<i>r</i>)	.409**	1							
	P-value (2-tailed)	0.004	–							
	N	47	47							
3. SCS	Correlation (<i>r</i>)	-.457**	-.343*	1						
	P-value (2-tailed)	0.002	0.025	–						
	N	43	43	43						
4. IES-Revised	Correlation (<i>r</i>)	0.226	.583**	-0.288	1					
	P-value (2-tailed)	0.160	0.000	0.076	–					
	N	40	39	39	40					
5. BDI-II	Correlation (<i>r</i>)	0.285	.409*	-.592**	.529**	1				
	P-value (2-tailed)	0.083	0.012	0.000	0.001	–				
	N	38	37	37	37	38				
6. TRGI Global Guilt Subscale	Correlation (<i>r</i>)	0.205	0.327	-0.287	0.356	0.136	1			
	P-value (2-tailed)	0.337	0.119	0.174	0.088	0.526	–			
	N	24	24	24	24	24	24			
7. TRGI Distress Subscale	Correlation (<i>r</i>)	0.151	0.180	-.507*	.464*	.675**	0.240	1		
	P-value (2-tailed)	0.481	0.399	0.012	0.022	0.000	0.259	–		
	N	24	24	24	24	24	24	24		
8. TRGI Guilt Cognitions Subscale	Correlation (<i>r</i>)	0.002	0.113	-0.365	0.052	0.211	.576**	0.165	1	
	P-value (2-tailed)	0.991	0.597	0.080	0.811	0.323	0.003	0.441	–	
	N	24	24	24	24	24	24	24	24	
9. Time Spent in Therapy (Months)	Correlation (<i>r</i>)	-0.116	0.118	-0.015	-0.158	-0.206	-0.153	0.161	-0.249	1
	P-value (2-tailed)	0.443	0.456	0.929	0.366	0.250	0.519	0.497	0.290	–
	N	46	42	38	35	33	20	20	20	46

*.p < 0.05 level (2-tailed), **. p < 0.01 level (2-tailed).

Note. N refers to the number of participants who filled out all items on both the scales/questions being correlated.

Note. TOSCA: Test of Self Conscious Affect; TRSI: Trauma-Related Shame Inventory; SCS: Self-Compassion Scale; IES-Revised: Impact of Events Scale-Revised; BDI-II: Beck Depression Inventory 2nd Edition; TRGI: Trauma-Related Guilt Inventory

3.3.4 Multiple Linear Regression Analyses

3.3.4.1 Model 1: Testing the Moderating Potential of Self-Compassion (SCS) in the Relationship between PTSD (IES-R) and CSA Shame (TRSI)

The second aim of this study was to investigate the direct relationship (i.e. direct effect) of PTSD levels (measured by the IES-R) on CSA shame (measured by the TRSI), while testing the potentially moderating variable of self-compassion (measured by the SCS). A multiple regression analysis using Model 1 (for moderation with one moderator) in PROCESS Macro was conducted (X-variable=IES-R score, Y-variable=TRSI score, W-variable (moderator)=SCS score).

Results of this first regression showed that the overall model is significant ($R^2=0.40$, $F(7.6)$, $p<0.001$). However as noted in Table 3.3 and Figure 3.1, while there is a significant direct positive relationship between IES-R (PTSD) scores and TRSI (CSA shame) scores ($B=0.40$, $SE(B)=0.12$, 95% CI[0.15, 0.65], $t=3.29$, $p<0.01$), SCS scores (self-compassion) did not show a significant moderating effect on this relationship ($B=0.007$, $SE(B)=0.007$, 95% CI[-0.007, 0.02] $t=1.05$, $p=0.3$).

Table 3.3

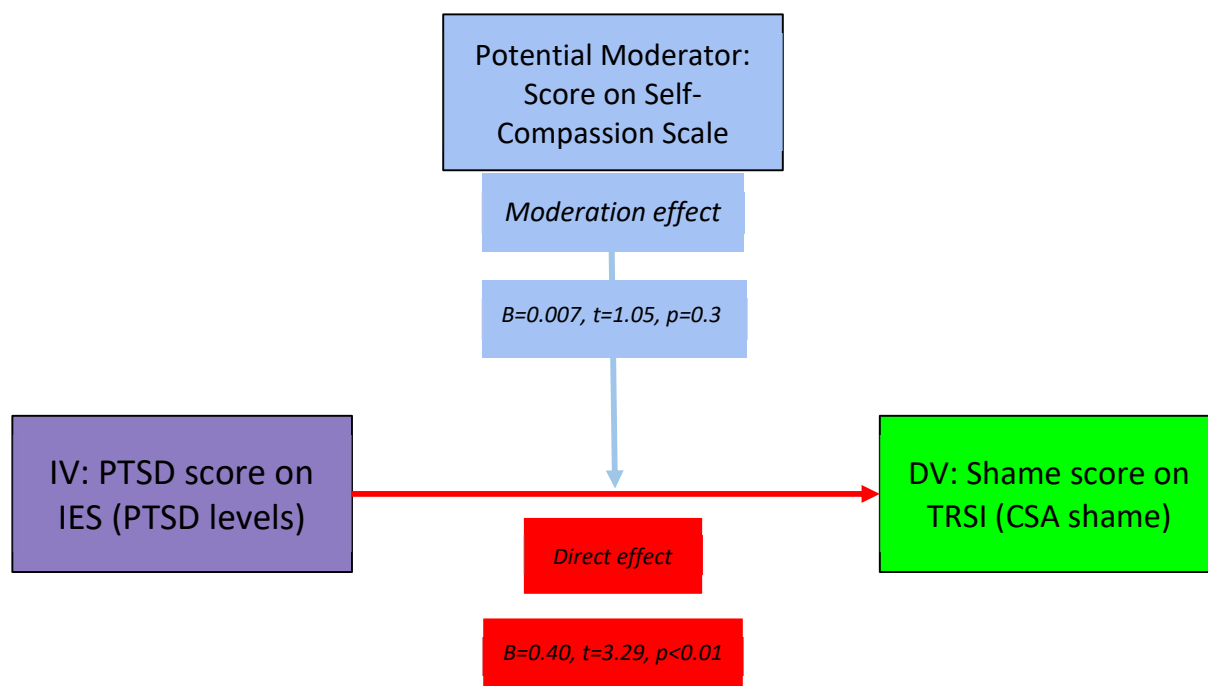
Regression Model 1: Testing the Moderation Potential of Self-Compassion in the Relationship between PTSD (X) and CSA Shame (Y)

	Beta Coefficient (B)	SE (B)	t	p	Lower Limit CI	Upper Limit CI
Constant	66.7983	2.6972	24.7660	0.0000	61.3226	72.2740
PTSD (IES Score)	0.3998	0.1219	3.2800	0.0024	0.1523	0.6472
Self-Compassion (SCS Score)	-0.2388	0.1554	-1.5364	0.1334	-0.5543	0.0767
Interaction term (PTSD x Self-Compassion)	0.0073	0.0069	1.0528	0.2997	-0.0068	0.0214

Note. Outcome variable is CSA shame as measured by the TRSI.

Figure 3.1

Multiple linear regression model 1: CSA shame as variable predicted by PTSD, with potential moderator self-compassion



3.3.4.2 Model 2: Testing the Mediating Potential of Self-Compassion (SCS) in the Relationship between PTSD (IES-R) and CSA Shame (TRSI)

The third aim of this study was to test the direct effect of PTSD levels (measured by the IES-R) on CSA shame (measured by the TRSI), with the potential mediating variable of self-compassion levels (measured by the SCS). A multiple regression analysis using Model 4 (for simple mediation) in PROCESS Macro was conducted (X-variable=IES-R score, Y-variable=TRSI score, Z-variable (mediator)=SCS score).

Results of the second regression showed that the overall model is significant ($R^2=0.38$, $F(10.86)$, $p<0.001$). However as noted in Table 3.4 and Figure 3.2, it is the IES-R scores (PTSD) driving this significant relationship, and not SCS scores (self-compassion); while there is a significant direct positive relationship between IES-R (PTSD) scores and TRSI (CSA shame) scores ($B=0.44$, $SE(B)=0.12$, 95% CI[0.21, 0.68], $t=3.82$, $p<0.01$) SCS scores (self-compassion) did not show a significant mediating effect on this relationship ($B= -0.23$, $SE(B)=0.16$, 95% CI[-0.54, 0.09] $t= -1.45$, $p=0.15$).

Table 3.4

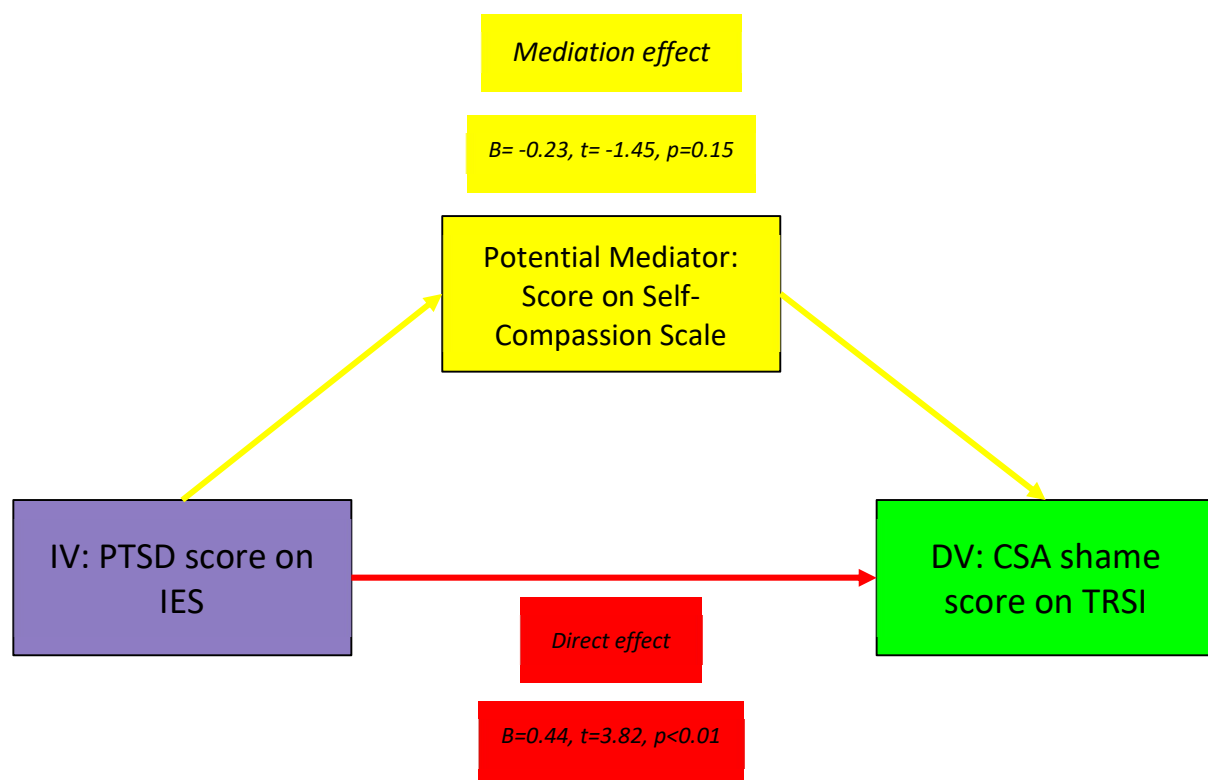
Regression Model 2: Testing the Mediation Potential of Self-Compassion in the Relationship between PTSD (X) and CSA Shame (Y)

	Beta Coefficient (B)	SE (B)	t	p	Lower Limit CI	Upper Limit CI
Constant	47.1085	14.4170	3.2676	0.0024	17.8689	76.3481
PTSD (IES Score)	0.4413	0.1155	3.8218	0.0005	0.2071	0.6755
Self-Compassion (SCS Score)	-0.2257	0.1552	-1.4548	0.1544	-0.5404	0.0889

Note. Outcome variable is CSA shame as measured by the TRSI.

Figure 3.2

Multiple linear regression model 2: CSA shame as variable predicted by PTSD, with potential mediator (self-compassion)



3.3.4.3 Model 3: Testing Self-Compassion (SCS) as a Moderator in the Relationship between CSA Shame (TRSI) and Depression (BDI-II)

The final aim of this study was to investigate the direct effect of general shame (measured by the TRSI) on depression (measured by the BDI) while testing the potential moderating variable of self-compassion (measured by the SCS). A multiple regression analysis using Model 1 (for moderation with one moderator) in PROCESS Macro was conducted (X-variable=TRSI score, Y-variable=BDI-II score, W-variable (moderator)=SCS score).

Results of the third regression showed that the overall model is significant ($R^2=0.42$, $F(7.82)$, $p<0.001$). As noted in Table 3.5 and Figure 3.3, there is *no* significant direct relationship between TRSI scores (CSA shame) and BDI-II scores (depression) ($B=0.24$, $SE(B)=0.12$, 95% CI[-0.02, 0.49], $t=1.9$, $p=0.66$), and therefore there cannot be a significant moderating effect of SCS scores (self-compassion) on this relationship ($B=0.007$, $SE(B)=0.007$, 95% CI[-0.007, 0.02] $t=1.05$, $p=0.3$). However, interestingly there is a significant direct negative relationship between SCS scores (self-compassion) and BDI-II scores (depression) ($B= -0.46$, $SE(B)=0.12$, 95% CI[-0.71, -0.21] $t= -3.71$, $p<0.001$), reflecting the significant correlation found between the two.

Table 3.5

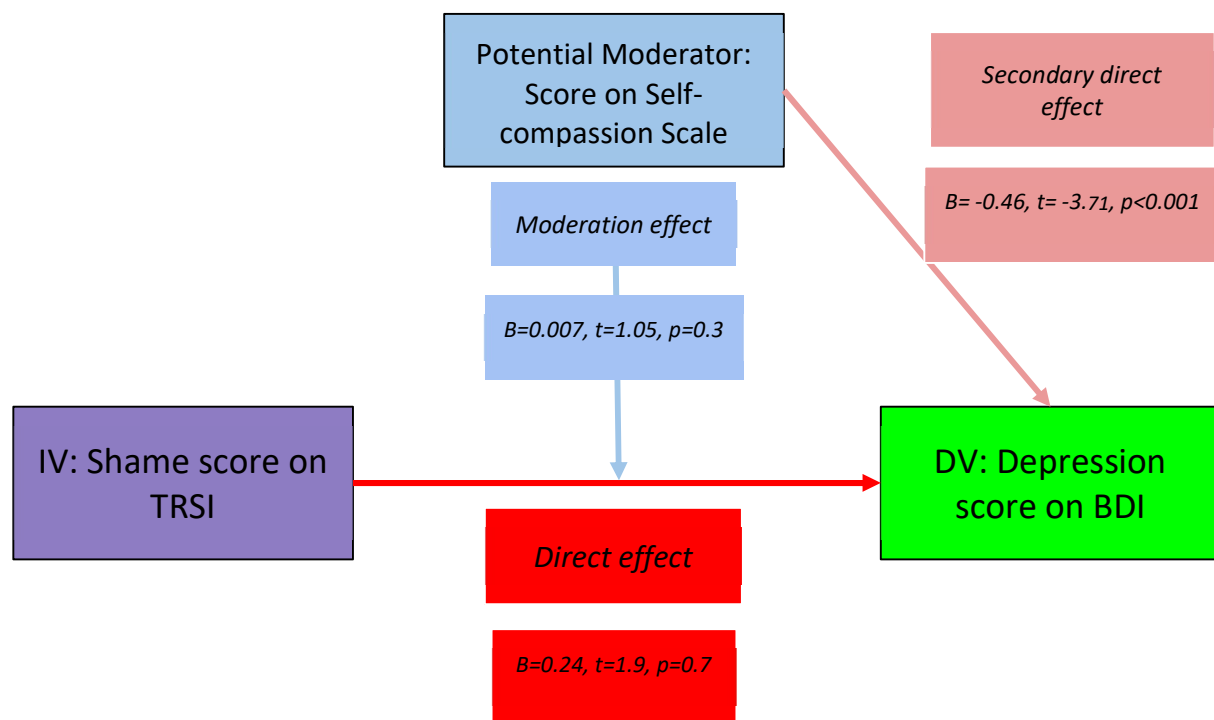
Regression Model 3: Testing the Moderation Potential of Self-Compassion in the Relationship between CSA Shame (X) and Depression (Y)

	Beta Coefficient (B)	SE (B)	t	p	Lower Limit CI	Upper Limit CI
Constant	51.1438	2.1353	23.9518	0.0000	46.7995	55.4881
CSA Shame (TRSI Score)	0.2355	0.1237	1.9034	0.6570	-0.0162	0.4872
Self-Compassion (SCS Score)	-0.4580	0.1233	-3.7147	0.0008	-0.7089	-0.2072
Interaction term (CSA Shame x Self-Compassion)	-0.0042	0.0067	-0.6319	0.5318	-0.0178	0.0093

Note. Outcome variable is depression as measured by the BDI-II.

Figure 3.3

Multiple linear regression model 3: depression as variable predicted by shame, with potential moderator (self-compassion)



3.4 Discussion

Based on the research gaps identified in Chapter 2, this study aimed to quantitatively investigate the existence and strength of relationships between CSA-related shame (measured here using an existing, validated tool for trauma-related shame), and other outcomes (depression, PTSD, self-compassion, trauma-related guilt, and general shame). A secondary aim of the study was to assess the suitability of the existing trauma-related shame measure for use with CSA survivors. The sample for this study was drawn from three recruitment sites: a psychological clinic for CSA survivors, Facebook support groups for CSA survivors, and a service for migrant women. Interpretations of important statistical results from the study are described below, after which recommendations for future research and study limitations are discussed. The regression models tested demonstrated adequate power to detect large effect sizes, but were not sufficiently powered to detect small or medium effect sizes (this would have required more participants.)

Therefore, future research should aim for larger sample sizes in order to detect smaller effects that may be present.

3.4.1 Interpretations of Study Findings

One of the main relationships tested in this study was that between CSA-related shame and general shame. As expected, a significant, positive correlation (of moderate strength) was found between CSA-related shame (TRSI) and general shame proneness (TOSCA-3), indicating that each measure is tapping into related constructs, but that they are still measuring distinct types of shame. This result also provides some support for increasing the use of the TRSI in clinical settings (a use for the scale that Øktedalen et al., 2014 recommended), in particular for those with trauma histories, at least until a more specific scale for this population is developed.

The correlation may suggest that people who are experiencing high levels of trauma-related shame are also generally more shame-prone. However, the nature and direction of the relationship, and whether general related shame in the case of CSA survivors is actually different from CSA shame, is unclear. This is partly due to the extremely early age at which shame develops in this population – as discussed later on in Chapter 4. It is clear that the shame developed in the aftermath of CSA is hard for survivors to separate from their sense of self (i.e. their core traits or identities). What this implies is the need for a larger-scale validation study of the TRSI and TOSCA-3 in a sample of CSA survivors in order to test if the factor structures of each remain the same, or whether there is a need to add items (or create a new scale) targeting CSA-specific aspects of shame.

In terms of trauma-related guilt, none of the subconstructs of the TRGI showed significant correlations with CSA or general shame, which was a slightly unexpected result, as shame and guilt are conceptually interrelated to some extent. On the other hand, the lack of correlation can be viewed as support for the two constructs in fact being distinct, at least based on the factors measured by the scales used in this study.

Another major relationship that was analysed was that between PTSD and CSA-related shame; in relation to this, self-compassion was tested as a potential mediator and moderator of the relationship. As expected, a significant positive correlation of moderate strength was found between PTSD and CSA-related shame, which supports previous research findings (Andrews et al., 2000; Dorahy et al., 2016; MacGinley et al., 2019; Saraiya & Lopez-Castro, 2016). It is also of interest that there was *no* significant correlation between PTSD and general shame, which further supports the view that there are important conceptual differences between the two, and that PTSD does not necessarily trigger the facets of shame measured by the TOSCA-3. Moreover, while there was a significant negative correlation of moderate strength between CSA-related shame and self-compassion (indicating that people with more self-compassion experience less shame), there was surprisingly no significant correlation between PTSD and self-compassion despite expectations.

In terms of the PTSD-self compassion-CSA shame relationship, when a regression model was run (Model 1 in the results section) to investigate the moderating potential of self-compassion, no significant moderation effect was found; only a significant direct effect between PTSD and CSA-related shame came through in the regression, reflecting the correlation between the two. Similarly, the regression model testing the mediating potential of self-compassion also resulted in a lack of a significant mediating effect.

These results partly reflect the correlations described in the paragraph above, in that there was a lack of a relationship between self-compassion and PTSD (at least using the measures in this study), despite a significant correlation between PTSD and CSA-shame. However, the lack of significant mediation or moderation by self-compassion indicates that this concept most likely works in parallel with CSA-shame and PTSD rather than through them.

The last major relationship investigated was that between CSA-shame, depression, and the potential for self-compassion to moderate the relation between these variables.. A significant positive correlation of moderate strength was found between CSA shame and depression, as

expected, which supports previous research findings (Åslund et al., 2007; Chang et al., 2018; MacGinley et al., 2019; Newman et al., 2000; Yaroslavsky et al., 2022). A significant negative correlation of moderate strength was also found between depression and self-compassion, also supporting previous research (López et al., 2018; McLean et al., 2018; Pullmer et al., 2019). However in the moderation analysis conducted, while the overall model was significant, the direct relationship between CSA-shame and depression was nonsignificant, indicating that CSA-shame did not directly predict depression levels in this sample. The lack of a direct relationship also means that self-compassion could not have a moderating effect. The significance of the overall regression model in relation to these factors was therefore driven by a secondary direct (negative) relationship between self-compassion and depression—a relationship that reflects the significant correlation between the two and suggests that people in this sample who possessed more self-compassion also exhibited fewer symptoms of depression. The nonsignificant direct relationship between CSA-shame and depression, despite a significant correlation, may also be a result of the test not being sufficiently powered to detect small or medium effects, which may have been the case for these two outcomes.

Finally, this study was interested in exploring whether time in therapy had any correlation with the outcome measures investigated. Interestingly, time in therapy did not correlate with any other measures, somewhat contrary to expectations. While previous research is not totally conclusive about long-term therapy being universally beneficial (Knekt et al., 2016; Kreidler & Einsporn, 2012; Nordmo et al., 2020), and outcomes depend on the type and intensity of the long-term therapy used, it was hypothesised that due to the uniquely fundamental and traumatic origins of CSA-related shame, long-term therapy would likely be more beneficial to survivors than short-term therapy.

One reason for this finding could be that, in this sample, the average time spent in therapy was relatively low, at just over two years (with a ± 40 -month standard deviation). As will be discussed in Chapter 4, CSA survivors' healing journeys are almost always life-long, and lasting

improvements in emotional and behavioural outcomes do not seem to appear until several years, perhaps even a decade, into therapy (as observed by the service providers interviewed in the next chapter). So the range of time participants in this study had spent in therapy is likely not wide enough to capture significant changes in any of the outcome measures.

3.4.2 Limitations

Several limitations are seen in this study, many stemming from the ethical and resource constraints inherent to a PhD programme.

Firstly, the final sample size (37 fully-completed surveys) was quite small, due to difficulties in recruitment as well as participant dropout during the course of the survey. Because of this, the study's analyses were not sufficiently powered to detect small or medium effects in the analyses, but rather only large ones. The failure to detect mediation and/or moderation effects could hence be a result of this rather than true representative findings. Participant dropout was likely a result of a combination of factors, namely the length of the survey (those doing the survey on their phones—likely many of the migrant women—would have therefore found the survey to be even longer), and the academic nature of some of the language used (considering as well that some participants may not speak English natively). Some of these factors are described below in further detail.

There is therefore a need to attempt to replicate these findings in a larger sample, perhaps as a replication of Øktedalen et al. (2014) where factors structures of the TRSI and the other outcome measures are investigated in a CSA survivor population through factor analyses. As noted in the Methods section, one way this limitation could have been avoided with regard to recruitment from HSE sites, is targeting ethics applications at multiple HSE regions simultaneously, rather than placing reliance on gaining approval in one region first to then allow easier access to other regions. It was not anticipated that the initial region targeted would unfortunately decide to withdraw from the process, so a greater awareness is now in place that such eventualities are possible and that additional contingency plans need to be put in place.

Furthermore, emphasis was placed by the Ethics Committee on the idea that it would be problematic to recruit survivors from the general/community population, as there was a high likelihood of recruiting survivors who had not engaged with counselling or other social services previously, and who may not have timely access to mental health services in case the survey caused them distress. Whilst feedback from the TCD Human Research Ethics Committee on the ethical applications and amendments submitted encouraged the approach taken here, it is clear that further consideration needs to be given to how a sufficient sample can be recruited in this manner to power relevant statistical analyses.

That said, it can be argued that the approach of only recruiting survivors via service providers, and moreover, that using gatekeepers to determine which of those survivors was informed about the survey at all, takes significant agency away from those not connected to a service. Considering how important a sense of agency is to CSA survivors, having been denied it for much of their lives, this recruitment approach could feed into and exacerbate the sense of shame and self-doubt that often permeates their lives already. The survivor-researcher consulted for this project (who acted as gatekeeper for the Facebook groups), also questioned this approach, mentioning the lack of opportunity that survivors in the general population would have to have their voices heard; using a different approach, this could be entirely avoidable and would afford survivors more respect. The lack of inclusion of these survivors also makes this study's data much more specific and less generalisable, which does not ultimately benefit our understanding of shame and the potential development of policies and measures to target it.

Over the past couple of decades, there has been an increased emphasis on how vulnerable populations should be addressed and consulted in social sciences research. Much of this discussion is led by members of these vulnerable groups themselves (such as people with disabilities or chronic illness, sexual abuse survivors, the LGBTQ+ community, etc.), who advocate for a more active role in research. This is contrary to the passive role of a 'research object' normally

imposed on them by researchers (Alyce et al., 2023; Barker et al., 2023; Schlingmann, 2023; Vaughn & Jacquez, 2020).

Methodological advances in psychological research have led to the development and use of several categories of participatory research that consider the input of potential beneficiaries of the research (Vaughn & Jacquez, 2020). One such approach that may be feasible in future quantitative research with CSA survivors is Community-Based Participatory Research (CBPR; Israel et al., 2005), which has a history of being used in psychology research (Collins et al., 2018). This approach has also been successfully used in sexual abuse research, with a recent systematic review by Willmott et al., (2023) showing that the increased agency and empowerment promoted by participatory research methods seems to lead to more meaningful participant engagement. Furthermore, policy changes or novel interventions resulting from good participatory research are more likely to be accepted by stakeholders.

A novel type of 'own voices' method that may be gaining momentum is survivor-controlled research, an approach developed by and for (child) sexual abuse survivors (Russo, 2012; Schlingmann, 2023). This methodology attempts to erase the distinction (and inherent hierarchy) between researcher and 'research object' that traditional research methods (even the most participatory or progressive ones) embody. This is done, for example, by having survivors themselves brainstorm research questions they would like to study, and then create research groups to do so. The survivors then engage in iterative design and data collection methods (and organise training sessions for skills they may not be familiar with), and consult an invited scientific advisory board when necessary. This level of participation of stakeholders seems to be the direction in which a lot of social science is headed, thereby making the field more democratic in nature.

Lastly, an additional suitable tool for increasing the involvement of survivors at various stages of research, is a charter published by the UK-based collective Survivors Voices (Perot & Chevous, 2018) that researchers or organisations can sign onto if they want to involve survivors in

the research process. The charter, which is in a pilot stage, includes a checklist for researchers to ensure transparent, empowering, and safe participation of survivors at all stages of research, and can act as a method of quality control and evaluation for researchers. It also emphasises the importance of survivors wielding agency regarding their ability to participate in research. A combination of elements of CBPR and other methods described in the previous paragraphs, and tools for evaluation of the success of these elements in individual studies is necessary in any future research to generate data considered legitimate and actionable by survivors.

In relation to the clinical resources available in case of participant distress, a suggestion (and one which would enable the participation of survivors not connected to a clinic or service) is for future research to obtain funding for a standby therapist who could be hired during recruitment periods. This would allow the timely provision of psychological support for participants who would not otherwise have immediate access to appropriate services, who could then be transitioned into support from other organisations over time, should it be needed. It is also possible that such research could enlist clinically validated internet-based therapy programs for intermediate care (such as SilverCloud, a platform used by the HSE as a supplementary mental health service) (*SilverCloud*, 2024).

Another limitation of the current study was the ultimately negligible amount of data gathered from the non-WEIRD population sampled (the clients from the service that supported migrant women). Despite extensive efforts to recruit participants from this pool, only three participants' data were complete enough to utilise in the final analysis, and only eight women started the survey at all. Even in this context, where the researcher is not in contact with participants, there may be a lack of trust or intimidation involved—many women at this service are also somewhat distrustful of researchers/institutions based on their past experiences, and may not have had interest in sharing any information about themselves for research (even with anonymisation).

A number of other issues with the administration of the survey emerged in relation to the low participation from the migrant women's population. These included the length of the survey and the added difficulty of completing the survey on a mobile phone. Based on the lead researcher's experience, it is known that most of the women involved coming to the service do not have access to computers/laptops (which is very different from the two other population pools that were sampled), and therefore conduct any internet-based activities on their phones. Despite the lead researcher's best efforts to create a mobile-friendly version of the survey, it still appeared much longer and more cumbersome on a phone screen than it did on a laptop screen. This likely dissuaded the five other migrant women who started the survey from going past the demographic questions. Indeed, the appearance of the first Likert scales would have been understandably off-putting.

There are also issues of language and literacy barriers that many of the potential migrant participants would have faced, and the possibility that many of the women were not used to responding to research surveys—this taps into the larger discussion about needing to adapt survey methods to different populations. While for some populations, translation of surveys is enough to guarantee participation, for others, such as many asylum seeker and refugee groups, survey methods must be adapted to account for not only language, but literacy level, familiarity with Western research methods (such as consent forms), and preferences for method of survey administration (Bloch, 2004; Heller et al., 2014; Ismail et al., 2014; Masood et al., 2019; Nicholson et al., 2015; Vujcich et al., 2022).

The research suggests face-to-face recruitment and administration of surveys (i.e. having an interviewer, ideally from the same community/language group, ask the survey questions to participants and record their responses) is much more conducive to engagement in low-literacy populations or populations not confident in their writing/reading abilities in the language of administration (Batres et al., 2018; Bloch, 2004; Nicholson et al., 2015; Vujcich et al., 2022). Furthermore, I observed during my PhD work that a large number of clients are eager to come to

face-to-face events in order to talk to other people because they often do not have a social network, and are therefore looking for outlets to talk about their experiences. This is very conducive to face-to-face administration of survey questions, though it is important that the person administering the survey has very good rapport with the client.

A related limitation is the lack of participants from other non-WEIRD populations, particularly from other countries, despite desires to do so. Resource constraints (lack of a research team and budget for survey translation/recruitment of research assistants, and the length of the ethics process being the largest barriers) prevented the expansion of the study survey to other countries.

Researchers in India, for instance, were contacted at the beginning of the survey ethics process, and feasibility of conducting the survey with local populations there was discussed. This idea came about through my acquaintance with a social science research organisation in and a non-profit for CSA prevention in India. We also contacted a psychiatrist in India who had worked on the topic before. Preliminary discussions were held with these potential recruitment sites to establish what would need to be done to roll out the survey with local populations, in terms of additional ethics applications, survey translations, and adaptation of the survey methodology to the needs of the local populations (e.g. training up local staff to administer the survey verbally). Ultimately this plan did not go forward as the total time it would have taken to complete these tasks properly, in addition to going through another ethics process at Trinity College, would have been too long. However, it would seem appropriate for future research to incorporate marginalised populations and cross-cultural populations into research right from the design stage (and ideally from the grant application stage) of the project, rather later on in the process. This is where participatory research principles come into play again, and tools such as the Large-Scale Multi-Country Replication Checklist (Jarke et al., 2022) and guidelines for effective collaboration with researchers in non-WEIRD regions, such as those elaborated in (Puthillam et al., 2023), must be consulted.

Another, expected, limitation of this study was the limited participation of male survivors. As discussed as one of the themes in Chapter 2, male survivors (of both SA and CSA) are less likely to participate in research about their abuse for a variety of reasons. These reasons include being more unwilling than women to admit that they were abused, being socialised to not share their feelings, and shame related to the perceived loss of their masculinity (Thomas & Kopel, 2023; Violato & Genuis, 1993). Male survivors may be additionally reluctant to respond to surveys out of fear that their information may somehow be exposed to people they know, possibly resulting in judgement.

A possible reason for this might be that since the study, and hence the recruitment materials did not explicitly target men (although the poster created for the clinic, intentionally included a graphic with both a male and female drawing), male survivors may not have felt that the study was relevant to them or that their perspectives were being sought. This could be addressed in future research by either tailoring the aims of the study to exclusively look at men's perspectives (as most of the research involving men in Chapter 2 does), or making sure extra efforts are taken during recruitment to reach out to male survivors, perhaps through sexual abuse services specific to men.

On a related note, interestingly there were three non-binary identifying participants, which seems high in relation to the likely size of the non-binary population (unfortunately there are no concrete statistics on the size of the non-binary population in Ireland).

Another limitation was that this study used a measure of trauma-related shame as a measure of CSA-related shame. This was an intentional choice, since (as found in Chapter 2), there does not seem to be a dedicated measure of CSA-related shame. Therefore in order to take the first step towards finding out exactly what dimensions of CSA shame a future measure must include, the next best option, a trauma-related shame scale, had to be utilised instead. And while the study's results do show that trauma-related shame seems to capture some of the experience of CSA-related shame, they still suggest that there may be elements of the experience of shame

specific to CSA which are not captured by a general trauma-related shame questionnaire. The need for a CSA-related shame questionnaire is one potential future research need, which is discussed next.

Finally, this study analysed the combined results from three different recruitment sites. This may be viewed as a limitation in the sense that there is likely to be some heterogeneity between these groups which this study was hence not able to explore. However, it was the small sample size that largely necessitated combining the three samples and what prevented subgroup analysis. Without the statistical ability to compare results from each group, the study was unable to comment on how certain population-related factors may have influenced the relationships tested. However, on the other hand, this approach allowed us to boost the overall sample size and thereby increase the statistical power of the main analyses that were performed.

3.4.3 Future Research Needs

As noted above, existing measurement tools for shame, including the TRSI, may not capture the nuanced and distinct shame experiences of CSA survivors. That said, a necessary caveat here is that, whatever work is done in the future to help develop a CSA-related shame specific measure, there will always be inherent limitations to such self-report tools. The reliance on self-report scales presents limitations when attempting to measure shame in CSA survivors, who may face considerable difficulties in expressing their emotions openly and accurately. Fear of retraumatization or the potential consequences of revealing their experiences, such as legal implications or familial strife, can lead to underreporting on the scale to protect against further emotional harm. In the case of people who may have yet to disclose their CSA, it becomes even more difficult for, say, a therapist to identify the existence of toxic shame in them through a self-report scale alone.

In light of these challenges, the development and utilisation of measurement tools other than self-report scales for shame in the context of CSA are essential. The incorporation of behavioural measures, which focus on observable actions and responses (such as the Facial Action

Coding System; Ekman & Friesen, 1976), or clinically-administered assessments conducted by trained professionals, can provide a more comprehensive understanding of the survivor's emotional landscape. These alternative measurement approaches offer the potential to bypass some of the limitations inherent in self-report tools and may yield a more accurate depiction of the survivor's shame experience, enhancing both research and clinical practice.

Such caveats having been made, there would appear to remain a necessity for a CSA-specific measure of shame. CSA represents a particularly sensitive and stigmatised form of trauma, and the shame experienced by survivors is often even more inseparable from the sense of self than non-CSA-related shame. Survivors may endure complex feelings of guilt, self-blame, and stigma. Maladaptive or toxic shame appears to be a type of shame particular to survivors of childhood abuse (MacGinley et al., 2019; Tangney, 1998). Such shame is often not observed in non-abused populations. This form of shame extends beyond acute feelings of embarrassment, guilt, or similar – it represents a fundamental disruption of one's self-concept, causing survivors to internalise the traumatic event as a reflection of their inherent flaws or unworthiness. All this renders the measurement of shame in this context especially challenging--add to this the time and staffing constraints that clinicians/psychological clinics are often working under (necessitating that clinical assessments are completed relatively quickly), and the development of an appropriate and usable tool becomes even trickier.

Researchers must be urged towards assessing CSA-related shame as its own concept, separate from both trauma-related and generalised shame. CSA-related shame arises from the boundary-violating nature of CSA and a betrayal of trust. This shame is consequently heavily influenced by the circumstances of the survivors' trauma, including by beliefs about themselves that the abusers may have conditioned into them from very early on in their lives, and the manner in which disclosures are handled. Those affected by CSA-related shame may not be able to reference its origins and triggers are unique to the CSA context and require specialised therapeutic approaches to address the complexities of this experience.

In short, the development of a CSA-specific measure of shame appears to be a pressing research and clinical need. The next thesis chapter (Chapter 4), through its qualitative studies of shame in CSA survivors, aims to contribute to this process by providing further data on shame in the context of CSA, to help inform the design of such a questionnaire by future research projects.

Chapter 4: Survivor and Service Provider Experiences and Perspectives on Shame in the Context of CSA

4.1 Introduction

4.1.1 *Gaps in Qualitative Research on CSA and Shame*

As discussed in Chapter 2, there is good quantitative evidence that therapeutic interventions are able to reduce levels of shame in survivors of CSA (Ballantine, 2012; Bowyer et al., 2014; Cohen et al., 2004; Deblinger et al., 2006; Ginzburg et al., 2009; Görg et al., 2017; Hansen et al., 2007; Talbot et al., 2011; Valerio & Lepper, 2009). It therefore appears likely that adult survivors of CSA who have and have not been through the process of psychological therapy have distinct experiences of shame. This makes research with survivors of CSA who *have* been through psychological therapies particularly informative, as these individuals have the potential to offer insights into pre- and post-therapy experiences of shame, as well as provide information about both what led to experiences of shame and what helped mitigate such experiences in the therapeutic process.

The first aim of the current study was to better understand the experiences of shame, and changes in this experience, in adult survivors of CSA who have undergone psychological therapy. Given that the results from Chapter 2's qualitative evidence synthesis revealed the need for more shame-specific qualitative research (particularly in reference to survivors' experiences with therapy), an in-depth interview research design was judged best to achieve this research goal. Furthermore, a negligible amount of qualitative studies assessed in Chapter 2 were carried out in Ireland. As Chapter 1 points out, the unique and unfortunate position of Ireland when it comes to the inculcation of shame culture via Catholicism and colonialism has left a long-lasting legacy in Irish society, one which affects survivors to this day; a detailed examination of this specific topic in the Irish context, discussing specific instances and events that may have contributed to an increase in shame in the survivors, is necessary to begin seriously working on policy changes and public campaigns that will ultimately benefit survivors of not just CSA, but other types of abuse and sexual violence.

In addition to interviewing adult CSA survivors who had been through therapy about their experiences of shame, the current study also took the innovative step of attempting to triangulate this with perspectives of psychological and social service providers. Whilst the process of triangulating perspectives of patients and care-providers has been widely utilised in a number of areas, from cardiac surgery (Gainer et al., 2017) to mental health care (Mason et al., 2004), this has yet to be done on the issue of shame in (adult) CSA survivors.

Such an approach offers a range of benefits. First, it helps establish if clients and service-providers have a shared understanding of how shame manifests and is experienced by survivors, as well as what the sources of this shame are. Were there to be a significant disjunct in these experiences, this would be a notable and clinically relevant finding and have important implications for how therapists and other service providers should be trained in relation to CSA. Second, it offers a chance to explore if what service providers think is helping address shame is also experienced in this way by the client. Finally, it offers a way to explore if clients are internalising the views of shame provided by psycho-education work by service providers. Whether a shared understanding and vocabulary of shame exists is again clinically relevant.

The original intent with this study was to do a high-level thematic analysis based on survivor and service provider interviews—however, the project was also open to taking a case-study approach in the case of a small number of participants and significantly different experiences.

4.1.2 The Importance of Highlighting Migrant Perspectives on CSA, Shame, and Female Genital Mutilation (FGM)

During the course of the PhD, the opportunity to incorporate research on female genital mutilation (FGM) arose. Due to the strong links between FGM and CSA (as explained below), it was decided that an expert on FGM at the migrant women's support service would be interviewed

for this study, thereby allowing us to gain insight into how shame might affect those with FGM histories.

FGM is the partial or total removal of external female genitalia or other injury to the female genital organs for non-medical reasons (World Health Organisation, 2024). It is a form of sexual abuse that affects around 200 million girls and women globally, and is recognised as a violation of human rights and as a form of child abuse. FGM is practiced in various cultures under the guise of tradition, religion, or as a rite of passage; while it has not historically been practiced in Ireland, increased migration in the past decade or so from regions of the world where FGM is more prevalent, has meant that women with FGM histories are present in the country at higher rates than ever before—an estimated 6,000 women living in Ireland have experienced FGM (Health Service Executive, 2022). The increased risk of girls in Ireland being made to undergo FGM, resulted in the creation of the Criminal Justice (Female Genital Mutilation) Act in 2012.

Predictably, all types of FGM are associated with adverse physical and mental health outcomes, such as excessive bleeding, shock, and death in the short term, and complications in childbirth, pelvic inflammatory disease, and urinary/menstruation problems in the long term (Sarayloo et al., 2019; World Health Organisation, 2024). Hence, researching FGM is crucial within the broader context of CSA research, as it represents a specific subtype of the abuse and often coexists with other forms of CSA.

FGM has strong connections with the practice of early and forced marriage (Karumbi & Muteshi, 2017; Seff et al., 2020; UNICEF, n.d.; United Nations, n.d.). In affected societies, FGM is often couched as a ritual that prepares young girls for marriage (the implication being control over their sexual behaviours, hence ensuring virginity until marriage). FGM is therefore frequently part and parcel of the norms surrounding early and forced marriage and can be a way for society to know that girls are ready for marriage. Addressing the intersection of FGM, CSA, and early marriage is therefore critical to any knowledge generation and cultural intervention that targets CSA.

As migration to Ireland from regions of the world that are highly affected by FGM continues to increase, civil service organisations such as NGOs, healthcare providers, and local authorities will need up-to-date quantitative and qualitative research in order to pinpoint which aspects of survivors' experiences they will need to target, and how. Unlike, for instance, the United States, United Kingdom, and Canada, non-European migration into Ireland only began to pick up relatively recently, and as a result the country has had much less time to accommodate the varying physical and mental health needs of migrant populations—this is yet another reason that now is the ideal time to start incorporating migrant populations into more all Irish healthcare research, rather than researching the two populations in silos. As some of the most marginalised members of Irish society, migrant women affected by FGM (typically refugees and asylum seekers, but other categories of migrants as well), deserve to have their experiences represented in CSA research from the get-go.

Chapter 3 provided valuable data on the limitations of mainstream survey methods when it comes to the refugee and asylum seeker population in Ireland, and suggests ways in which these methods must be amended in order to enable the participation of migrant women, particularly ones living in Direct Provision. The current study is the first (to our knowledge) to qualitatively examine FGM in the Irish context and through the lens of CSA; and although it was not possible to directly interview women with experience of FGM due to ethics and resource constraints of the PhD programme (detailed below), the service provider interview from the aforementioned service supporting migrant women offers crucial, actionable insights into the gaps in Irish healthcare training and public awareness regarding FGM.

4.1.3 Objectives and Ethics of Survivor and Service Provider Interviews

As discussed in Chapter 3, shame is clearly associated with negative psychosocial outcomes in adult survivors of CSA, is closely tied up with experiences of disclosure, and can be exacerbated by family and societal responses. The first aim of the current study was to better understand how any potential experiences of shame in adult survivors who had undergone psychological therapy

had evolved over time, including at time of disclosure, and how these had affected the individual. The second aim of the study was to explore how both familial and societal responses to the individual had, over time, impacted the survivors' experiences of shame. The final aim of the study was to allow participants to highlight any element of their experiences that they wished to develop, not guided by pre-specified research questions—this element of the study was based on biographical narrative interview methodology (BNIM; Corbally & O'Neill, 2014; Mooney, 2021), which originated in research on nursing. The aims of this methodology are to elicit the biography (whole life story), narrative (the way in which the person tells the story), and interpretive elements (how the narrative may be understood by society and the researcher) of the person being interviewed. At its core is allowing the interviewee to first narrate their story (based on a brief prompt given to them at the start of the interview) uninterrupted. Most recently, Mooney (2021) confirmed the feasibility of this methodology in adult CSA survivors.

As mentioned above, interviews with psychological service providers were then undertaken to help triangulate findings. To this end, interviews with service providers employed a similar template of questions (detailed in the methods section below,) which dealt with clients' experiences of shame as well as familial and societal drivers of such shame. However, interviews with psychological service providers also looked to explore clinician-specific elements of working with shame. In terms of therapist-specific findings, Chapter 1 discussed the differences and inter-relations between shame, guilt and self-blame. The therapist interviews were hence also designed to explore how therapists understood these three interrelated concepts, and the related patterns they have observed over the years in their clients' healing journeys. Therapist interviews also looked to understand how, and to what extent, therapists worked with shame, as well as what they viewed could be done (at multiple levels in society) to help mitigate survivor shame.

Whilst there are a number of potential ways to explore these above questions, including longitudinal work (which avoids issues of retrospective recall) a qualitative cross-sectional design was employed here, due to time and ethical constraints of the PhD (discussed below), and in order

to help identify issues that could inform the design of such subsequent longitudinal work. While initially a result of the limited scope of recruitment I had, interviewing survivors who had been in CSA-specific therapy for a long period of time addressed many of these potential issues, while also allowing for a more in-depth exploration of the topic that might not have been possible with participants who were at the very beginning of their therapeutic journeys, who may not have much experience talking in depth about their abuse. Limitations of this approach are discussed at the end of this chapter.

When performing research with any population, particularly survivors of trauma, ethical concerns must be at the forefront of research design. Given the resource limitations of a PhD programme, a core concern was to ensure that participants had access to appropriate sources of support in case of distress. To that end, the rationale for recruiting adult CSA survivors who had been through/are going through psychological therapy dovetailed well with these ethical concerns. Firstly, pre-existing psychological support was already in place for such participants (as they were recruited from the psychology clinic at which they were receiving therapy), which they could access in a timely manner in case of distress stemming from the interview process. Secondly, working with this population meant working with a population who were likely to feel relatively safe and equipped to talk about their experiences of shame, compared to individuals who had not been through psychological therapy. Whilst it is clearly important to understand the experience of shame in people who have not been through psychological therapy, working with the current population allowed the research to proceed in a manner that ensured, as far as practical, that the interviews would cause minimal distress and that, if any distress occurred, that support could be offered in a timely manner.

4.2 Methods

4.2.1 Ethical Approval and Data Protection

Survivor and service provider interviews were approved (as separate applications) by the Faculty of Health Sciences Level II Research Ethics Committee at Trinity College Dublin (Appendices K and

L) on April 28th, 2023 and November 9th, 2023 respectively. As part of the ethics process, Data Protection Impact Assessments were carried out for each application and approved by the Data Protection Officer at Trinity College Dublin.

4.2.2 Recruitment and Data Collection

4.2.2.1 Survivor Interviews

Recruitment for the survivor interviews was conducted at the same psychotherapy clinic as in Chapter 3, over the course of five months. The clinic provided a letter of collaboration in which they agreed to recruit participants for the study. Participants were recruited via a gatekeeper at the clinic (the clinical director), who was asked to share invitational emails and participant information leaflets (Appendix O and N) with clients of the service whom they deemed capable of participating in an in-depth interview. Recruitment was limited to this clinic, to ensure that participants would have timely access to their psychologist if they experienced any distress from the interview.

As stipulated by the ethics committee and following the same procedure as in Chapter 3, the lead researcher (SAV) was not directly involved in the recruitment of participants, to avoid any possibility of participants feeling pressured to take part in the study. Initial contact between survivors and the lead researcher was made via email by survivors interested in being interviewed, who were informed of the study by the gatekeeper. Three survivors contacted the lead researcher during the recruitment period; two of them went ahead with the interview, and one of them ultimately decided not to go ahead with the interview.

Due to COVID-19 constraints and the adoption by the general population of online meeting services like Zoom and Microsoft Teams, participants were given the option to be interviewed in person (government regulations permitting) or online. The first interview was conducted in person, on the Trinity College Dublin campus, and the second was conducted over Zoom. Both interviews were recorded on Zoom, in order to utilise the speech-to-text functionality it offers to create an initial transcript afterward. Consent forms were signed on the day of the

interview in the case of the first interview, and one day in advance, digitally, for the second interview. The duration of the interview with the first participant was around two-and-a-half hours. The duration of the interview with the second participant was around one-and-a-half hours.

4.2.2.2 Service Provider Interviews

As a way to triangulate the accounts of the survivors, and to provide more context and insight into shame from the point of view of professionals engaging with survivors, service providers were interviewed. Service providers were recruited from the same clinic as above, as well as from the service that supported migrant women described in Chapter 3. Both the clinic and the service provided letters of collaboration confirming that the lead researcher was permitted to interview selected staff members of their organisations. At both sites, the service providers were known to the lead researcher beforehand in a professional capacity (as they had been helping the lead researcher with participant recruitment for the study detailed in Chapter 3 as well as the survivor interviews). Once ethical approval was granted, the service providers were approached formally via email by the lead researcher, who shared a participant information leaflet (Appendix N) and consent form (Appendix M) with them. Two therapists from the clinic, and one staff member from the service (who works in the area of women's health) agreed to participate. Consent forms were signed digitally and sent back to the lead researcher via email a couple of days before each interview. All three interviews took place over Zoom, and all lasted approximately one-and-a-half hours.

4.2.3 Interview Schedule

4.2.3.1 Survivor Interview Schedule

A semi-structured interview protocol was developed in collaboration with therapists from the clinic, and was additionally informed by biographical narrative interview methodology (Corbally & O'Neill, 2014; Mooney, 2021) (Appendix P). The protocol aimed to address the following general areas relating to the survivors' experiences of their abuse and shame: 1) past and present emotional responses to the abuse; 2) past and present familial responses to the abuse; 3) past and

present community responses to the abuse. Space was given for the survivors to fully describe their experiences, with minimal interruption from the interviewer; follow-up questions were asked about topics in the interview schedule that had not yet been addressed, until the majority of the topics in the protocol had been touched on.

4.2.3.2 Service Provider Interview Schedule

A semi-structured interview protocol was also used for the service provider interviews (Appendix Q). The protocol spanned the following areas: 1) the service provider's background and a description of the service's clientele; 2) the service provider's understanding of shame and guilt in the CSA landscape; 3) therapeutic/service approaches to shame in clients; 4) patterns observed by the service providers in relation to: client emotional responses, disclosure and shame, and generational changes in clients' responses to abuse/development of shame; 5) patterns in familial and community responses to CSA; 6) socio-cultural influences on clients' experiences of shame; and 7) clinical/service provision suggestions to target shame in clients.

4.2.4 Data Management

Following the protocol approved in the DPIA, all email correspondence between the lead researcher and the survivors was deleted permanently from the lead researcher's email account after the period of accuracy-checking of the transcripts (described below). No other contact information (such as phone numbers, social media details, etc.) was shared between the lead researcher and the survivors.

Digital copies of consent forms are stored in a secure Google Drive folder in the lead researcher's Trinity College-administered account, and which requires two-factor authentication to access. Upon the conclusion of the lead researcher's PhD (post-viva), consent forms will be transferred to a similar digital folder belonging to one of the lead researcher's supervisors, for a period of seven years as suggested by data protection guidelines. Hard copies of consent forms were scanned and uploaded onto the aforementioned folders. The hard copies were then

destroyed in secure disposal locations on the Trinity College campus (Aras an Phiarsaigh, School of Psychology).

Interviews, whether in person or online, were audio-recorded on Zoom (no video recording was saved). The speech-to-text functionality on Zoom created initial, rough transcripts of the interviews, after which the lead researcher went back over the transcripts while listening to the recordings to correct any mistakes and anonymise the transcripts, following the approved data protection guidelines. Transcript anonymisation was conducted within 24 hours of the interview to make sure all names and other identifying details, such as location names, occupations, etc. were removed. At this stage the audio recordings were permanently deleted from the lead researcher's laptop. Transcripts were then sent back to the participants for accuracy-checking, for which they were given two weeks to respond with any requested changes. Anonymised transcripts will be retained until the end of the lead researcher's PhD (until submission of the final thesis, post-viva), at which stage they will be permanently deleted from the lead researcher's laptop and the secure, Trinity College-administered folder they are stored in. Pseudonyms are used for all participants in the results section.

4.2.5 Analysis

Given the small sample size of both sets of interviews, an interpretative phenomenological analysis (IPA; Smith, 1996; Smith et al., 2012) approach was deemed the most appropriate analysis method, as the specificities of the lived experiences of the survivors, and the lived work experiences of the service providers, were of primary interest to this project. Although IPA was the overarching framework used in this study, elements of case study strategy do appear in the study. This was to some extent unavoidable due to inherent similarities between the two strategies, such as the desire in both to derive meaning and interpretation within the context. Furthermore, utilising data from multiple perspectives of a situation and triangulating these with survivor accounts is more closely aligned with case study strategy rather than IPA. However, due

to the challenges with survivor recruitment that were encountered, deviating from a strict IPA strategy was deemed overall more beneficial to the final results.

As discussed in the introduction, the heterogeneity of accounts was respected by performing one-by-one analyses of the interviews using standard IPA protocol, from which major themes in each participant's interview were drawn out. Results of the survivor interviews are laid out separately, explaining themes and subthemes present in each participant's account. Themes from the service provider interviews are presented in a combined format, as they largely serve to add contextual and supporting clinical information to help understand the survivors' experiences. Any novel or unique insights emerging from the service provider interviews are elaborated on in more detail.

4.3 Results

4.3.1 Themes Identified in Survivor Interviews

A summary of the two sets of themes that were identified in the survivor interviews is given in Table 4.1.

Table 4.1

List of Themes Identified in Each Survivor Interview

Niamh	Aoife
<i>Theme 1: Convergence of Self with the Abuse and People-Pleasing</i>	<i>Theme 1: Convergence of Self with the Abuse</i>
<i>Theme 2: Dissociation, Self-Doubt, and Distancing</i>	<i>Theme 2: The Effect of Shame on Disclosure</i>
<i>Theme 3: Bodily Shame</i>	<i>Theme 3: Fragmented Memories, Family Dynamics, and Guilt</i>
<i>Theme 4: The Effect of Shame on Disclosure</i>	<i>Theme 4: Dealing with Chronic Health Conditions: Impact of Shame, Guilt, and Self-Doubt</i>
<i>Theme 5: Internalising the Feeling of Being Non-Human</i>	
<i>Theme 6: Guilt</i>	

4.3.1.1 Survivor Interview 1: Niamh

Niamh (not the participant's real name) is a white Irish, college-educated woman in her early middle age, who has been undergoing therapy for over a decade. She began experiencing sexual abuse by her father when she was only a baby. This abuse continued till her father died when she was in early childhood. The abuse also involved the production of child sexual abuse materials (CSAM; photographs) which Niamh discovered in adulthood and suspected her father had shared with other people. As a child, Niamh had spent a lot of her time alone with her father, which had enabled the abuse to continue often and unnoticed by others, although there were some attempts by Niamh to flag physical pain symptoms to doctors or other adults which were not pursued further. Niamh's isolation contributed to the normalisation of the abuse and a delay in realising that the nature of her relationship with her father was destructive and not the norm. Niamh is unclear if her mother knew about the sexual abuse by her father, though Niamh suspects she did.

Theme 1: Convergence of Self with the Abuse and People-Pleasing

The first and most prevalent theme that emerged from Niamh's interview is a conflation of her entire sense of self with her abuse—that is, at the core of their experience of day-to-day life is the belief that they *are* their abuse. At several points in the interview, Niamh mentions that she finds it *“very hard to express or talk about the bad things that happened to me and separate that from feeling like I'm bad.”* This sentiment is repeated throughout the interview, at one point being expressed as such: *“internally I can't tell the difference between ‘my life wasn't normal’ and ‘I'm not normal.’ I don't see any difference.”*

The convergence of the abuse with her sense of self seems to be the overarching belief that permeates every interaction and experience in Niamh's life. Perhaps this is due to the abuse starting at a very young age (when she was a toddler), before Niamh was able to develop a sense of self separate from the abuse. The CSA experience, combined with the mixed messages Niamh

received regarding the (ab)normality of the abuse, led to Niamh developing a very skewed perspective of what the self can be.

Furthermore, considering the early start to the abuse and Niamh's earliest memories beginning once the abuse was already underway, the 'I am bad' perception of the self may have also developed as a way to make sense of why the abuse was happening. Niamh may have had no other way to 'justify' or understand why her father was abusing her, as she did not know him, or the wider world, before the abuse. In that sense, to Niamh there are no known precipitating 'actions' taken by her, her mother, or her father, no noticeable change in personality in the father, that triggered the abuse—one way she *can* explain the abuse, therefore, is via a belief that she 'deserves' it for 'being bad'. Messages from the external world then served to compound this self-perception. For instance, being told at school that *"if anybody hurts you or touches your privates or any of that stuff, you should tell your parents"* and from there extrapolating that *"it's okay for your parents to do that to you. And I was like, 'Oh, well, I don't think...it doesn't feel great. But apparently it's okay if they [your parents] do it [sexually abuse you]'."*

As Niamh grew older, the conflation of abuse and self, and the resulting shame, was further reinforced by her mother's emotional and physical abuse, which included her mother telling her *"what was happening to me was because I was bad,"* referring to the physical abuse the mother was inflicting. Perhaps the most poignant quote from Niamh, and one which perfectly describes this dynamic between the act of abuse and the sense of self, comes from a section of the interview where she questions her entire reason for being:

"I was literally born to be abused, like my parents had me and just instantly abused me, I was born to be in pain because I'm not good, I'm just shit, that's what I was born for."

Niamh also exhibits strong people-pleasing tendencies, both within the narration of her past and in terms of her behaviours during the interview, showing clear connections to her low self-esteem and internalisation of the feeling that she is inherently bad. This people-pleasing trait

seems to be an ingrained and almost automatic attempt at proving her worth or goodness to others, a response to her internalised shame. Niamh describes her mother as *“a very helpless adult woman,”* in contrast to her father, who *“was really big on being independent.”* As a consequence, Niamh took it upon herself to do chores around the house that her mother was unable to, but with a very clear objective of trying to please her mother, and negate the qualities her mother had convinced her she contained. This is exemplified in the following description:

“Before my mom came back to the house I'd absolutely scrub the house, try and have stuff all nice for her, make her bed for her so that when she walked in the door I could be like ‘I've cleaned your house, I've made your bed, here's a cup of coffee!’”

Furthermore, it seems these tendencies continue to inform Niamh's social behaviours. For instance, at the start of the interview, when the interviewer informed her that she could indicate that she needed a break whenever she needed, Niamh replied that the interviewer would need to enforce breaks as she would not be able to express her needs and interrupt the conversation, regardless of how uncomfortable or distressed she was. During the interview, while she maintained candidness throughout, at the start Niamh was more cautious of the amount of detail she shared during her descriptions of the abuse. At first, when she began the interview discussing the event that led her to seek counselling at her present clinic (the discovery of the CSAM her father had created of her), she avoided sharing details of the event, saying *“I'm purposely keeping it a bit vague.”*

The avoidance of detail at the start of the interview could be partially attributed to Niamh trying to establish how trustworthy the interviewer is. However, given her pattern of behaviour, and the fact that she begins to talk about the abuse in much greater, sometimes graphic detail (without being prompted) only a minute or two later, there also seems to be an element of Niamh wanting to protect the interviewer from having to hear these details, and perhaps not wanting to elicit a negative response from the interviewer towards her.

Another detail in Niamh's story that points to the fundamental tie between her sense of self and her experience of the abuse, is her keeping the photos of the abuse close to her body for an extended period of time right after she found them. She relates:

"I wouldn't let go of the photographs. I carried them around everywhere with me like in my pocket and like I kept, like, touching them in my pocket to make sure they were real. I didn't look at them."

While of course, the shock of the discovery may have led to a freezing response and the inability to consider other options, her choice of keeping the photos in her pocket, rather than in her bag, purse, or in another location (in a locked box at home, for instance,) seems to be a manifestation of the belief that she is inseparable from the abused child.

Moreover, being confronted with explicit evidence of the abuse so many years after its occurrence, during which Niamh was trying to move past its consequences through therapy, retriggered her shame, as if reminding her that no matter what she did to move on, the abuse would always be a part of her, as demonstrated through this quote: *"I sometimes still can't stop seeing them because when I see them and I see my eyes in them because I'm making eye contact with the camera."* The detail of the eye contact only deepens this connection; looking at the photos would feel like seeing oneself in a mirror.

It is also interesting to note that Niamh is conscious of this lack of separation of self and abuse when narrating her story, showing an intellectual understanding of this core belief while acknowledging that it is still a major aspect hindering her in day-to-day life. This is a testament to the progress she has made with her CSA-specific counsellors over the past decade—when combined with her forthcomingness in sharing details around the abuse, in a way it is also a demonstration of Niamh distancing herself from her experience, which may be related to her past and continuing experiences of dissociation (elaborated further below).

Theme 2: Internalising the Feeling of Being Non-Human

Another theme that emerged in Niamh's interview was the feeling of not being completely human/not fitting into society like other people do. As a direct result of the conflation of the abuse and the self, Niamh inhabits a world where she seems to have accepted a position as a perpetual outsider, or as she puts it, *"So yeah it's—you don't feel like a human, the same as other people."* Based on her descriptions of instances in her life that have highlighted this feeling for her, there are two aspects to this 'non-human' perception of herself. First, is Niamh's belief that she is missing some key information (instructions, perhaps,) for behaving 'normally' or more 'human-like', as if there is insider knowledge about how to talk, how to sit, how to relate to others, etc. to which everyone else except her is privy. Second, is the subsequent alienation that Niamh experiences as a result of this 'missing information', which serves to exacerbate her shame and avoidant behaviours.

Some of the first instances of her feeling 'not like a human' began in childhood, when she started to notice how her peers acted in the presence of their parents:

"I remember being in a car with my peers and their parents and feeling totally weirded out when they got in the car and they would just be little people--like I was a little person, it seemed like they were quite babyish when they were around their parents. Like and I understand it, they were being vulnerable with their parents."

In this moment, Niamh realised that the reactions her peers had to their parents differed significantly from hers; she found their casual, non-defensive, and friendly behaviours towards their parents unrelatable. Instead, her instinctual reaction when her peers were interacting with their parents, was *"I'll protect all of you guys from your parents because obviously you also need protection from your parents."* The drastic difference she noticed in the demeanour of her peers in relation to their parents triggered a feeling of disconnect in Niamh, as she realised that they do not need her help or protection, which is one of the few forms of peer-to-peer bonding that she could envision and provide.

Other events in Niamh's childhood served to intensify the belief that she is inherently different from her peers; in particular, adults in her life (they did not know about the abuse) reacted to her in ways that made her feel out of place and abnormal:

"people outside of my relationship with my dad just thought I was weird and would whisper about me, like fret over me but like in this Irish mother and granny way that was like pretending to be worried about it when they were just saying how terrible I was. That made me feel shit as opposed to like...and I was just supposed to like sit there and smile when I didn't know I was doing anything bad."

That adults, who are considered authority figures (and, to a child, have a good grasp on normality vs. abnormality), were the ones indicating that she was not like other children, would have been a damning realisation for Niamh, one which further deepened her shame and conviction that she would always be seen through the lens of what the abuse did to her. At several points in the interview Niamh describes awkward or uncomfortable social interactions making her "feel shit" like she does in the quote above; though not explicitly indicated, this phrase seems to be how Niamh expresses the feeling of shame in those interactions.

One of the seminal events in Niamh's childhood that has left a lasting impression, is a reaction from her father in a public setting:

"When I was about five or six I also misunderstood my relationship with my father and I thought what would make him happy is if the way we were at night was also the way we were during the day, and I tried to kiss him on the mouth in the Dart (public transport) once when I was about six. And even though he got really mad I thought that was something that should have happened."

This is a prime example of a situation in which Niamh thought she had all the correct information to navigate her relationship with her father in a 'normal' way, yet was blindsided by his reaction, launching her back into the uncomfortable limbo of not being quite normal or human enough. This event is also an example of the mixed messages Niamh received throughout her

childhood about the acceptability of the abuse. As mentioned in the previous section, Niamh was educated by adults to tell her parents if anyone touched her inappropriately, yet was not told what to do if it was a parent that was abusing her. Such messaging would have caused Niamh to question whether sexual abuse was only wrong when a stranger perpetrated it, or whether there had to be something seriously and inherently ‘wrong’ with her to be abused by a parent in the first place.

Similarly, at one point in Niamh’s teenage years, a doctor examining Niamh noticed signs of abuse. However, rather than informing authorities of this, he went back to Niamh’s mother to tell her about his suspicions of abuse. Predictably, this event did not lead to further investigation of historical CSA, once more affirming to Niamh that the abuse was not serious or abnormal enough to warrant action from the adults around her, and that disclosure was pointless.

Theme 3: Dissociation, Self-Doubt, and Distancing

The third major theme that was uncovered, was Niamh’s experience of dissociation, and its lingering effects. Dissociative tendencies, a common behavioural outcome for CSA survivors, have long been a part of Niamh’s life. As a child, Niamh describes dissociating during class, and then being scolded for doing so by her teachers, who were not aware of the abuse she was going through: *“My teachers when I was at the age that the abuse was happening, they spent their lives like giving out to me because I was daydreaming, but I was dissociating”*. Yet again, Niamh is singled out among her peers as behaving ‘abnormally’, further cementing her core belief that she is somehow not fully human, and creating self-doubt in her ability to comport herself according to social norms. While at this stage in her life she is able to recognise and accept that her teachers were the ones in the wrong here, it is clear that the fundamental feeling of alienation from society still affects Niamh on a day-to-day basis.

Niamh further describes her experiences with dissociation, stating that during especially distressing times, when the dissociation took hold of her, it felt like *“being underneath in a swimming pool under the water, and then you come up again and everything is so loud”*. The experience of drifting in and out of lucidity (while having a hazy recollection of events that

occurred during the period of dissociation and then being overwhelmed by the world once the dissociation stopped) intensifies Niamh's shame when it comes to 'fitting into' society; adjusting to social settings and to daily life during and after dissociative episodes can be difficult and confusing. This acts as yet another signal to Niamh that her experience of life is fundamentally different to that of other humans due to her being 'damaged' in some way.

In addition to the full-blown dissociative episodes Niamh experiences, there are other, less severe manifestations of dissociation that come up in her life which perhaps have a slightly different effect and purpose than the type of dissociation described above. For instance, Niamh describes a behaviour she terms 'weather-girling', in reference to weather presenters on the news—this is a way she sometimes talks about her abuse to others, distancing herself from it in the process *"it's just like how I talk about my trauma sometimes, like 'Coming in from the east we have a big childhood full of all forms of abuse!'"*

There is an element of dissociation from her experiences here, which might make it easier for her to talk about the abuse. Moreover, using the relatively light-hearted metaphor of a weather presenter to deliver her abuse experiences to others reflects Niamh's compulsion to please those around her—she wants to put others at ease, even if it means masking her own feelings and affect around the topic of her abuse. The desire to please people also ties in with the guilt Niamh experiences when she shares her story with others—this is elaborated on in the section on guilt below.

Lastly, Niamh recounts her habit of using the third person to talk about herself during her therapy sessions: *"In therapy right now I'd be talking in third person, like 'bad shit happens to Niamh'"*. Though not strictly a form of dissociation, it is clear that she uses this narrative technique to avoid directly experiencing some of the intense emotion that might result from talking about the abuse during her sessions. However, this technique (called *illeism*), which Niamh displays with her 'weather-girling' as well, is widely used in psychotherapy more generally, to nudge clients to

view and interpret situations from an outsider's perspective, and to look at the larger picture rather than fixating on details (Moser et al., 2017; Nook et al., 2017).

Nook et al. (2017) demonstrated an increase in participants' emotion regulation abilities when they used linguistic distancing techniques, such as talking about themselves in the third person. This finding was supported by Moser et al. (2017), with additional fMRI and event-related brain potential (ERP) data; participants who recalled negative memories while talking to themselves in the third person showed a decreased response in a region of the brain implicated in self-referential thought (the medial prefrontal cortex), while simultaneously maintaining activity levels (i.e. not causing increases) in fMRI markers of cognitive control. These studies imply that when used purposefully, third-person speech has the potential to aid in emotion regulation (particularly in the presence of negative or distressing thoughts) without recruiting additional effort to engage one's cognitive control.

However helpful these findings may be though, their applicability to survivors of childhood trauma like Niamh likely differs in magnitude and mechanism, given the strong link between survivors' negative memories and their sense of self. In Niamh's case, the third-person referencing and the distance it provides may be helpful to the extent that it allows her to open up during her therapy sessions without severe distress. Beyond this, it is unclear whether in the long term this way of speaking has in some way helped her decouple her identity from her abuse; as discussed earlier, Niamh clearly still views the abuse as part and parcel of her whole self.

Theme 4: Bodily Shame

In addition to a general, all-encompassing feeling of shame, Niamh also detailed instances of experiencing shame specific to her body or physicality—an outcome seen fairly commonly in survivors of sexual abuse. In one example from when she was around six-seven years of age, she explains: *"I felt like it [her vulva] was not a part of my body. It wasn't supposed to be there. And I hated it."* This alienation from her vulva soon led her to self-harm in an attempt to rid herself of the shame she was feeling but could not yet articulate:

“First time I ever self harmed, I was literally trying to work out what was going on. I got scissors and tried to cut off my labia majora because I thought that if they were gone I wouldn’t feel the way that I did.”

Niamh’s method of self-harm is an apt illustration of the self-abuse conflation discussed above, and of how excruciatingly difficult it is for many survivors to free themselves from this once the connection is made.

Further on, Niamh indicates other physical embodiments of shame—such as the urge to cringe sometimes when she showers, which she terms as ‘lemon thoughts’ (the feeling of sucking on a lemon):

“I get the lemon thoughts from like having a shower or bath and remembering what my body felt like washing and showering after I was raped, or making eye contact with myself in the mirror brushing my teeth and seeing the kind of dazed fear...like ‘why is this you? Why do I have to be you?’ Kind of body disgust.”

Body disgust was mentioned multiple times in Niamh’s interview, and as mentioned above, seems to have a deep connection with the repeated confrontation she has had with the photos of her abuse. Niamh’s discomfort in her body also seems to reflect a continuing theme of not belonging to herself when coupled with the dissociation and self-doubt—in addition to feeling like she does not belong in the human world, there is a sense in Niamh’s words that she doesn’t feel like her body and mind truly belong to her. Due to the repeated violations of her physical and mental boundaries caused by her abuser, Niamh’s agency over her body and identity were robbed from her at a young age to the point where, as a child, she wanted to be rid of parts of her physical self, and as an adult, is attempting to take back ownership of her body in different ways (one way being her decade-long engagement with CSA-specific therapy).

Her reclamation of body and identity might also be seen to some extent in her act of keeping the abuse photos in her pockets at all times—holding the photos close to her body may have created a sense of oneness with the girl she sees in them, and a realisation that despite the

dissociation she often felt, ultimately she embodies the girl in the photos. However, Niamh's process of regaining agency over her body seems to still have a long way to go, as evidenced by the entrenched bodily shame and disgust she experiences at times.

Theme 5: The Effect of Shame on Disclosure

Another important theme, and one which reflects general consensus in CSA research, is the effects of shame on disclosure of the abuse. Niamh's attempts at disclosing the abuse, some of which are described above, were often met with reactions from adults that ultimately shamed her in some way for doing so, such as doubt or ridicule. Moreover, she also describes her hesitancy to even start disclosing to professionals such as doctors—a hesitancy rooted in the shame that had already developed. She explains her mindset when she was first considering disclosure as a child:

“When I very first started disclosing any information about the abuse I was very vague—I was around nine. I didn't know I was having flashbacks—like full body flashbacks. And I didn't know what they were. I thought that I was going insane, so I approached that cautiously but yeah I saw a psychiatrist who was very nice...Yeah to me that wasn't that bad, he seems okay with all this mad shit that I'm experiencing so I started being a bit more open with him. But I never actually told him and I never actually said that it was my father.”

Even though she felt comfortable with her psychiatrist at the time, Niamh decided to not disclose the abuse. This decision is understandable in the context of past reactions of people like her mother, who in one instance scolded Niamh as a child for insinuating that she was being abused:

“At the time I used to get a lot of discharge. Retrospectively it was ejaculate coming out but I didn't know what that was as a child. So the next time it happened that I didn't know what all this stuff was. I caught it on a tissue and went to ask my mom what it was and she got very very angry. Very scary physically and emotionally.”

Given such experiences, it makes sense that Niamh would not have wanted to disclose other physical or psychological symptoms she was experiencing for many years down the line. By being berated for showing curiosity and concern about her body as a child, Niamh was made to feel as if she should have known better (a callback to feeling like she's missing the instructions to 'be human'), and by extension, that there was something fundamental missing from her character (tact, a sense of propriety, etc.), all of which would have contributed to the creation of the core pillar of shame that still dictates Niamh's thoughts and behaviours.

In addition to being dismissed by her mother when concerns were raised, Niamh also experienced a demoralising moment with a child psychiatrist who thought Niamh might have been experiencing abuse (even though Niamh had not disclosed anything to her). The psychiatrist mentioned that if that was the case, Niamh would have to go to the Gardaí and report it:

"But her answer at the time was if you were a child, if you were or are being abused you need to go to a Garda station to give statements. But that was too scary being told [that] if it was your mom she might be arrested—and that was too much. And she said she would have to declare anything I said if I do say anything, so it was never disclosed. I never disclosed anything. Up to a point, that was how I dealt with services and psychologists. If I didn't name names or infer who the person was, they didn't have to get me to report it or anything."

While the psychiatrist may have thought she was being helpful, in reality her words reduced the likelihood of Niamh ever disclosing the abuse to anyone. The way the prospect of going to the Gardaí was presented by the psychiatrist put the burden of deciding whether to report suspected abuse on Niamh, a child, rather than the adult (and the health professional) in the situation.

It is important to note that at the time this interaction took place, legal obligations such as mandated reporting of suspected child abuse by people in roles of caring for children had not yet been put in place. In fact, while legislation strengthening child protection started to emerge in

the 1990s (beginning with the Child Care Act of 1991), the first legal obligation toward mandated reporting only came into being in 2015, with the introduction of the Children First Act 2015 (which was only enforced from 2017). Before this legal obligation, suspected child abuse was reported at the discretion of the individual caregiver—and it is clear that many caregivers, such as Niamh’s psychiatrist, did not seem to be ethically compelled to do so.

Additionally, mentioning the possibility of one of her parents being arrested if she reports the abuse was not only counterproductive, but may have inadvertently appealed to certain cultural notions of ‘family honour’ (discussed in Chapter 2) that Niamh could have already internalised—it was implied that Niamh’s actions (being a result of who she is inherently) could potentially break apart the family. The desire to avoid further shame and judgement from those around her likely influenced her decision to not disclose. Ultimately, this exchange is illustrative of a common pattern reported by survivors in the literature, of people in positions of authority absolving themselves of responsibility when it comes to helping the child disclose.

What compelled Niamh to finally, explicitly disclose the abuse was being confronted with the photos of her abuse. As she puts it:

“And then after the photographs I didn't have a lot of choice in the matter. You can't after you find photographs like that. You have to tell them even if they don't want to see the photographs, you have to tell them.”

While she was not able to elaborate on exactly why she felt this urgent need to disclose, perhaps it was the re-experiencing symptoms (triggered by seeing the photos) that led her to realise two things: 1) that any doubts she may have had about her memories of the abuse, about how extensive or how real it was, were fully cleared, and 2) this was a new opportunity for her to begin her journey of counselling from the point of view of her abuse. It may have also been easier to bring up the topic at this point, as there was a recent and distinct event (finding the photos) that Niamh could draw on to begin a discussion with her therapist.

Theme 6: Guilt

The final theme with regard to negative outcomes relating to shame, is the lingering feeling of guilt in Niamh's life. While shame is the foremost self-conscious emotion faced by Niamh, she also feels a lot of guilt, specifically when it comes to talking about the abuse to clinicians and friends. Since disclosing her abuse after finding the photos, she has had to talk to many professionals as well as friends, about the abuse; the transition from never having talked about the abuse, to suddenly having to or wanting to talk about it a lot, can understandably be difficult, triggering various emotions and exacerbating her shame. Niamh expresses that she often feels guilty, as if she is burdening the person she talks to with the weight of the abuse: *"Oh yeah, no people didn't want to know and I used to feel very bad about having to tell people about it because they didn't know what to do with that information."* She is referring here to psychologists specifically, who sometimes reacted to her disclosure about the photos by being startled, and expressing that they did not know what steps to take next.

As is common in survivors of abuse, this kind of guilt (which is attributed to the survivor's actions and its consequences) is extremely intertwined with shame. In Niamh, both shame and guilt are triggered when she talks about the abuse to others:

"Niamh: So the first time I told this girl [about the abuse] like I was kind of like also thinking like 'if she tells people I will kill myself'. So that's my friend—and then after, my friend had a kind of disgusted reaction.

Interviewer: Like she was disgusted at the act but kind of made you feel like she was disgusted at you?

Niamh: That made me feel really bad."

So while her guilt is activated from assuming she is inflicting pain on her friend with her story, her shame is also rearing its head due to her friend's reaction, which Niamh instinctually feels is rooted in disgust at who she is (even though she knows on an intellectual level that her friend's disgust is aimed at the abuse/abuser). In this interaction, the self-abuse conflation is apparent once again, this time mired in another painful emotion, guilt.

Theme 7: Supportive Factors

In spite of the deeply entrenched shame that still impedes Niamh's day-to-day life, she signposts and displays a few supportive factors/behaviours that enable her to continue moving forward in her healing journey.

Firstly, her willingness to engage in CSA-specific therapy for over a decade, and her desire to contribute to research on the topic (knowing that the findings of this project will not directly affect her), is a testament to the high levels of resilience Niamh has developed over the years. Recent research in the area has identified resilience as a crucial trait in CSA survivors who are able to function and build a life after their abuse (Domhardt et al., 2015; Newsom & Myers-Bowman, 2017).

While Domhardt et al. (2015) identifies supportive family and community, an internal locus of control, and self-esteem as common precursors to developing resilience, these factors were clearly not present in Niamh's life growing up and in early adulthood—this further highlights the immense personal strength and deliberate perseverance Niamh had to harness in order to show up to therapy, work, etc. consistently. Her experience is also illustrative of the likely life-long nature of healing in CSA survivors—the cultivation of resilience in someone whose sense of self was manipulated and destroyed, and who was not allowed to experience control over their physical and mental selves, is predictably a very arduous task, and one that probably differs significantly from the resilience-development journeys of survivors of other forms of abuse. On the other hand, certain other factors cited in these studies, such as attainment of secondary education, mid-to-high familial socio-economic status, and caregiver level of education *were* present in Niamh's life, potentially contributing to the development of at least a base-level of resilience in her childhood.

Another helpful factor in Niamh's life more recently has been creating art. Toward the end of the interview, she explains how art acts as an avenue to process and externalise her emotions:

“The best way I have of getting what's inside onto the outside is through the arts. So I have like this painting—it's like words that people use when they're trying to be positive

about this whole thing and inside those words are like smaller other words. So it's like 'you're so creative' –but you're telling me I'm so creative, but the reality of that is like I didn't know what else to do. You know, I've always had a really big imagination because I needed to escape”

The physical act of painting might be a very literal way of asserting control over her body (something she feels very rarely), in the sense that she can direct her hands to do what she wants, to create a small piece of a world whose every aspect *she* determines. Furthermore, the act of transferring some of her thoughts onto the canvas, and giving them a physical form, seems to help her fulfil her need to ‘tear out’ the shame from inside her (as she attempted to do in childhood via self-harm); repeatedly bringing these shaming thoughts into the light, exposing them, might also weaken their impact over time.

Another therapeutic component Niamh has found helpful in addressing her shame-led low self-esteem, is a focus on self-compassion (mostly through Compassion-Focused Therapy [CFT]; Gilbert, 2014; Neff et al., 2007): *“I was lucky enough to have already done some work on compassion focused therapy, that was probably the most helpful to me”*, Niamh explains. As discussed in Chapter 1, one of the main targets of CFT is shame. Core values of the practice include having the client develop a sense of self-warmth and a non-judgemental view of the self, increase distress tolerance, and habituate clients to the use of compassionate language, imagery, and behaviours. So in many ways self-compassion is the opposing phenomenon to shame, as it aims to build one’s self-esteem in the face of hardship, rather than efface it; it is clear why Niamh would have found elements of CFT helpful. Her relatively positive experience with working on her self-compassion supports the general research findings on the use of CFT with survivors of sexual abuse (outlined in Chapters 2 and 3, and later in this chapter), and is also mentioned as an important clinical target by the two therapists interviewed for this study.

It is worth noting however, that in one of Niamh’s experiences with CFT (a group therapy setting she was in before disclosure), though she found the general process helpful, she was still

not comfortable with sharing her experiences or feelings publicly. To her, it seemed like the group was “for after you’ve disclosed it [the trauma].” This could be a useful insight to service providers using or considering compassion-centred approaches in their work: while CFT and related modalities offer immense benefits to survivors in the long-run, existing forms may not be suited to facilitating disclosure in their current forms (particularly if the CFT is not trauma-focused). In addition, the extensive limitations of global mental health systems cannot be overlooked when exploring the limitations of compassion-focused approaches.

When asked what clinical and societal factors might have aided Niamh in disclosing sooner, and whether she thought there was a role in this process for shame measurement tools, Niamh expresses the following:

“I find it very hard to express or talk about the bad things that happened to me and separate that from feeling like I’m bad. And I feel like having the questionnaires [that ask about shame] might have helped me bring it up and talk about it and express it. And the separation of having to actually say shit and just ticking a box. Does that make sense? That’s easier. When you know you just have to like tick the box.”

The fact that Niamh does not ever remember being asked—either in intake forms or by her therapists—about experiencing shame or related emotions before she finally disclosed and sought CSA-specific counselling, is an indictment on the quality of services available for survivors of any kind of sexual abuse. As she suggests, even just the addition of shame in a checklist of emotions the client is currently experiencing, for example, would go a long way in encouraging disclosure, as it would clearly signal that the service/clinician offers a safe space to survivors, and is capable of meaningfully working with the survivor.

4.3.1.2 Survivor Interview 2: Aoife

Aoife is a white Irish woman in her middle age who had over a decade of therapy. Like Niamh, Aoife’s abuse began when she was a very young child, and was perpetrated by close male family members (uncle and grandfather). However, unlike in Niamh’s case, Aoife was abused as part of

a CSA ring. The abuse continued until Aoife was in middle childhood, when it was eventually found out by her family (she had tried to tell them about the abuse a few years before, but was brushed off). Aoife did not report any abuse (sexual, physical, or psychological) from her parents, although like Niamh, to this day she suspects that her parents must have had some idea of what was going on.

While both Niamh and Aoife display significant clarity and an objective understanding of their trauma in their interviews, Aoife (perhaps due to being older and having been in therapy for longer) is more straightforward in identifying the themes she has come to see in her life with regard to shame. As a consequence, the general, overarching themes that have emerged from her interview were largely self-identified, reflecting the impact CSA-specific therapy has had on her ability to reframe the narrative of her abuse, and to take a different perspective on it (at least on an intellectual level). Aoife's interview was conducted over Zoom, during which she preferred to have her camera turned off; as a consequence it was not possible to interpret her body language.

Many of the themes appearing in Aoife's account echo those found in Niamh's interview, with very similar impacts on her development of shame and its effects on her current life (conflation of self and abuse, guilt, difficulty with disclosure, systemic and institutional barriers). A few additional themes, relating to Aoife's fragmented memory, struggles with chronic health issues, and strained familial relationships, depart from the themes in Niamh's interview, and are discussed in more detail here.

Theme 1: Convergence of Self with the Abuse

The first theme to come out of Aoife's interview is the conflation of her sense of self and the abuse, which parallels Niamh's experience. She acknowledges that regardless of whether or not her abusers face justice, she will never quite be free of her trauma and shame:

"I feel like I've got a life sentence with my trauma. I know I'll never be free of it. The aim is to work through it and come to a feeling where it's not really yours to hold

anymore, but it's very much still in my body. And every time I try to move forward it's like their hands are grabbing me from behind upon me back to us."

This quote also encapsulates how in both women's cases, while their intellectual perception of the abuse has changed over the years, their bodies and minds carry lifelong marks of it that inevitably seem to affect their day-to-day behaviours. Aoife's comparison of her trauma to a prison sentence is also interesting because of the (likely inadvertent, but still telling) implication that she somehow committed a 'crime' by being abused—and once again, at the core of this metaphor lies the deep shame that implicates survivors in their own abuse, by convincing them that they brought the abuse upon themselves through some character flaw.

Another quote further on in the interview points out a sort of 'meta-shame' that Aoife has noticed in herself:

"And it's like this marked me for the rest of my life, almost being ashamed that I can't let go of the shame."

Here is a striking example of the compounding and cascading nature of this kind of toxic shame; there seems to be almost an unconscious compulsion in Aoife to assign shame to every action of hers relating to the abuse (and sometimes ones unrelated to the abuse too).

Aoife also points out how blackmail from her abusers may have contributed to the solidification of the self=abuse identity:

"I'm not sure but it [the blackmail] was...my understanding of what was being said was that my granddad and my dad would be jailed. Whether or not that was blown out of proportion, but whatever the blackmail was, it [the consequences of disclosure] was exceptionally serious."

Here Aoife's abusers are trying to convince her that there is something wrong with *her* for 'blowing the abuse out of proportion', and are leveraging the possible jailing of her father (who was not involved in the abuse) as a way to both make her feel trapped, but also question her intelligence/imply that she is too young to understand the true implications of disclosure.

Theme 2: The Effect of Shame on Disclosure

The second major theme that emerged in Aoife's story, again reflecting the same type of experience as Niamh, is difficulties with disclosure. As the quote above illustrates, Aoife and Niamh both had similar experiences in attempting to disclose their abuse. Like Niamh, Aoife was scared into not reporting the abuse with the threat of imprisonment of her parents. In Aoife's case, this possibility may have sowed even more guilt and fear in her, as neither of her parents were involved in the abuse (and this was not the case for Niamh). Moreover, when Aoife did try to disclose the abuse, her concerns, like Niamh's, were brushed off by the very adults who were supposed to protect her:

"I believe I would have been maybe five, when one of my relatives abused me and I told his wife what had happened and she didn't believe me. So my parents pulled me aside and questioned me. And I started talking about everything. But they didn't believe me."

She goes on to describe yet another attempt at disclosure that was not pursued:

"My memories are a bit shaky, but I think I was brought to a child psychologist to try and talk me out of speaking about it because naturally, these are serious offences, but they thought I was just making it up. And they wanted to obviously put a stop to that."

A common thread between these two instances, as well as between Niamh's experiences with disclosure, is the inability of the adults involved, particularly family members, to accept the possibility of another family member committing acts of abuse. And while it is of course understandable that no one would want to imagine their husband/father/grandfather being an abuser, the level of denial seen in Aoife and Niamh's cases (and in the stories of far too many other survivors), only serves to placate non-abusing family members, absolve them of responsibility for further action, allow the abuse to continue, and inculcate more shame in the victims. The issue of family member inaction also ties in with the pressure to maintain family honour, as Aoife explains here:

“When I was a bit older, and it was uncovered and was brought up, you know, ‘the family name will be ruined if this gets out.’ There was this sadness, and like the guilt and shame, this burden that was placed on my shoulders, you know, don’t speak. It’s on you, It’s your fault if you speak and this gets out there.”

The consequences of her parents’ reactions to her disclosure have not left Aoife to this day. One of the long-term effects of Aoife’s negative experiences with disclosure, is a conviction that her words will not be believed:

“The not being believed is something that’s an old issue that’s stuck with me throughout my life in situations, like I’m dealing with a lot of physical health doctors who aren’t believing me and it really stirs up old feelings and old baggage.”

This, combined with her memory fragmentation (discussed in the next section) seem to have created a sort of ‘gaslighting’ situation in Aoife’s mind, leading her to question the integrity of her mind (another contributor to her shame). As a recent systematic review concluded, research over decades has demonstrated a link between reduced hippocampal volume (a brain region heavily involved in memory creation and retrieval) in people with CSA histories due to a chronic activation of the stress response system (Ahmed-Leitao et al., 2016); while this could be a realistic reason for Aoife’s memory problems, she has unfortunately been led to question the veracity of her fragmented memories itself, rather than accepting the truth of her experiences *and* the possibility of her memory problems being a direct result of the abuse.

Theme 3: Fragmented Memories, Family Dynamics, and Guilt

Another pattern highlighted in this interview, is that memory lapses and the seeds of doubt planted by the people around her in childhood cause Aoife to frequently question events surrounding her abuse, which has also led to her being unable to fully trust her parents’ accounts of these events:

“Recently I was working through a lot of trauma memories and it was putting me in a bad situation where I was finding it hard to be close to my parents. Last year, I made

myself sick with anxiety for a couple of weeks before I called my mom and asked her a few questions about what happened to me as a kid, and she denied a lot of stuff and said stuff didn't happen, which put me in a very confusing place, because then I was doubting myself. But then there were certain things she said that made me realise she was being very truthful. So that put me in a difficult position where I felt it's hard to trust them."

In an alternate version of her life, one in which her parents and other caregivers did not doubt her disclosures as a child and had validated her experiences, perhaps Aoife would be able to reconcile her mother's version of events with her own without the intense confusion and shame that ensues currently. In reality, in addition to the confusion and shame, Aoife has likely also experienced guilt for doubting her parents' intentions and accounts; guilt also features in her relationship with her brother and other children abused by her perpetrators (discussed below).

Over the years, Aoife has maintained a complex but overall intact relationship with her parents. While she has moments like the one described above, in which she is frustrated by and suspicious of her parents' accounts of the abuse and its aftermath, and is hurt by the harshness with which her mother sometimes treats her, she also appreciates the support she got from them after the abuse was finally uncovered (something Niamh did not experience from any of her family or community members). She recognises that, perhaps out of their own sense of guilt, they made financial sacrifices to ensure she received appropriate psychological and medical care through the rest of her childhood:

"Maybe they didn't give me what I needed, but they always did their best for me. I know when I was maybe in my teens, my mom was saying, 'we can't really afford your therapy anymore,' because it would have been all private, and there was expensive medication and hospital visits and things like that. So sometimes she'd come to me and say, 'Look, we can't afford this anymore,' where my dad would always go, 'Well,

we have to.' I know over the years, aside from the emotional strain, I did put a lot of financial strain on them."

There is an element of people-pleasing and guilt on Aoife's part in this quote; despite being aware of the (arguably severe) shortcomings of her parents' actions regarding her abuse, she still feels the need to justify her mother's concerns over private therapy sessions, for example. As her parents still live with her, she also seems to feel an obligation to care for them—this obligation had recently intensified at the time of the interview, as Aoife's mother had recently suffered from some health issues:

"My memory is exceptionally poor, I've got years blanked out and my brain, important parts of my life blanked out of my brain. And a few months ago, my mom had [health issues], and there was this sudden realisation of 'you probably won't ever get your answers because you can't bring them [questions about what the mother knew of the abuse] up.' And when she had the [health issues], there was this feeling of compassion, obviously not wanting her to die, and being very worried about her."

After the period of her mother's health issues, Aoife experienced conflicting emotions towards her, yet ultimately, it seems like guilt is the final emotion she is left with when thinking about their relationship:

"But also this conflict of this anger, and this guilt for and the shame for thinking ill of her, and for the complicated relationship we've always had...so it just feels like there's this constant conflict within me of: every time I feel like maybe I'm justified in having an issue with someone, there's a part that always puts the other person above that."

Aoife's guilt also extends to the self-harm she engaged in as a teenager dealing with the abuse: *"And it's a very complex thing where I feel guilty for what I put them through for times where I was maybe very recklessly irresponsible."* On the surface, this guilt stems from particular actions taken by Aoife (conforming to the general definition of guilt); however the guilt itself is in

turn a manifestation of her deep-rooted shame in the sense that it distorts her perception of her actions to place blame on herself for them.

What Aoife feels the most guilty about by far, is her perceived role in the involvement of other children in the abuse. Compared to the discussion of guilt toward her parents, she talked about this aspect of her guilt in much more detail and with much more remorse. Since Aoife was abused as part of a CSA ring, eventually other children that Aoife knew were pulled into the abuse due to their proximity to her (making it easier to groom them). Aoife feels responsible to some extent for these children being abused, and guilty for not having done anything to protect them:

“In time, I grew to see it wasn't my fault. But when more memories started to come back to me and the extent of it, and the fact that I feel guilt, whether it's family members or other people, you know, friends who would have been abused with me, I still can't let go of the guilt and shame over that...and, you know, there was other people who I kind of –maybe, I suppose maybe knew something might happen, but I had been abused for so long, on my own, that I didn't want to go through it alone. So I didn't bring them to be abused, but I maybe put them in situations where that opened the doors for them being abused. And that's very difficult to reconcile.”

Both Niamh and Aoife suffer from the guilt of inflicting or passing on the pain of abuse onto others, albeit to very different extents; the context around Aoife's guilt, and especially her admission that she did not want to be abused alone, adds a layer of (what she sees as) 'justified' self-blame—it would be worth investigating if in such situations, long-term memory fragmentation may be a way of avoiding feeling the guilt associated with the abuse, and actions/inaction that may have taken place.

Theme 4: Dealing with Chronic Health Conditions: Impact of Shame and Self-Doubt

The final theme that was identified in Aoife's interview was the impact of self-doubt, memory fragmentation, and the consequent shame on her experience of her chronic health issues and

interactions with healthcare service providers. Aoife has been dealing with several unexplained physical health symptoms since adolescence. This was a topic on which Aoife spent considerable time during the interview, indicating the impact it has had on her life. Part of the reason her symptoms have remained unexplained for so long, is the dismissiveness with which Aoife has been treated by doctors and other healthcare professionals when she has tried to get answers:

"I'm dealing with a lot of physical health doctors who aren't believing me and it really stirs up old feelings and old baggage...Yeah, so I have a huge history of bizarre symptoms. Every part of my body-and I'm engaged with about five or six different departments—my tests come back clear. So they're saying your tests are normal, there's nothing wrong with you, it's in your head. Or the things that happened on my body aren't physically possible to happen, but they're happening on a daily basis. But it's a whole thing of not being believed, despite long term symptoms and dysfunction."

The self-doubt and resulting shame discussed in the previous sections has only been reinforced over the years by inadequate responses and treatment by doctors. One of the ways in which healthcare providers have dismissed Aoife's concerns, is by attributing her symptoms to her trauma:

"I have a lot of gynae problems and they're saying, it's the trauma or-I'm on a high dose medication-or say it's your medication. And it's kinda like what happened being dismissed or being told it's not real, or, like, I'm aware, when I go to any department that I have a lot of baggage that maybe another patient might not. But still, it feels like you're being discredited."

While there is some evidence that psychosomatic (somatic symptom) disorders are more prevalent in people with a history of childhood abuse (Carlier et al., 2016; Paras et al., 2009; Romans & Cohen, 2008), as Romans and Cohen (2008) conclude, much more rigorous research is needed in the area in order to make clinically-relevant links between the two. Moreover, a potential link between abuse and somatic problems should not negate the need for healthcare

providers to treat a patient's concerns the same way they would in patients without a history of abuse.

As a result of the way Aoife's health symptoms were treated, she started to doubt herself and her bodily experiences even more: *"And then sometimes I doubt myself, and then just sit down and kind of go, are they right? That place where you question yourself and doubt yourself is a horrible place to be."* One of the reasons this dismissiveness is so impactful for Aoife, is how closely it parallels her experience of disclosing (which in itself was extremely distressing to her): Aoife feels let down by those that are supposed to take care of her, the same way she was let down by her parents at her first disclosure.

However, one particular incident relating to her health seemed to validate her concerns, and confirm that she was not imagining her symptoms:

"I had a hysterectomy and I was going in with all this awful pain that nobody could understand. But a doctor gave me a hysterectomy based on my symptoms. And then when they dissected the organs, they were just a mess of veins and congestions and cysts. And she was really surprised. She was like, 'I've never seen anything like this', you know, 'clearly you were in a lot of pain.' But it's very rare that you get that acknowledgement."

It is unfortunate that Aoife only received validation of her long-term symptoms after such a major medical procedure, and not earlier on—even a simple acknowledgement of the existence of her symptoms, and the 'truth' of them, might have helped reduce her levels of self-doubt, thereby improving the quality of her life at least somewhat.

Another facet of Aoife's negative experience with the healthcare system is the lack of control over her body and life she was left feeling, which also directly harkens back to the lack of control she felt during her abuse:

"I'm in surgical menopause since I was 36. So I had a whole host of hormonal issues before the menopause. So with the hormones it feels like you've no control because

it's just like you're a prisoner to your body and you're a prisoner to your hormones.

There's very little that I feel like I have any control over."

Like with Niamh (in terms of her dissociation), Aoife's life is marked by a persistent belief that she ultimately has no say or control over what happens to her. Even when she is conscious of this feeling and its origins, Aoife is not able to overcome the voice in her head that compels her to believe this. As she explains by way of a dream she had, the way Aoife tries to deal with the issue is by telling herself that she is choosing to accept the lack of control:

"And I do try and let go of that need to control because when you can't control something, and all this stuff is happening to you, and you feel like you're being bombarded every now and again, I might have a more positive moment where it's like, stop worrying about it...but then there's this old trauma feeling like it's gonna happen anyway. I had a dream a while ago, where I was looking over myself being abused. And I was telling this little girl 'just give in', because it's like, you've got a choice, if you just give in...you don't want it to happen, but you feel like you have some agency if you're just letting it happen, as opposed to it happening to you."

What started as literal, forceful denial of control over her body in childhood, was eventually transformed into a more generalised feeling, almost a learned helplessness, of having no agency overall. Yet it is clear that Aoife is trying to overcome these automatic psychological responses in whatever way she can, which is a sign of her resilience, as well as a sign of the progress that years in therapy has led to. Nevertheless, what Aoife would have really appreciated in her interactions is the following:

"And don't give up on me. Don't dismiss me. Don't put me aside when you know, it's this very kind of lonely feeling. And you're screaming and crying and saying please look at me, please. You know, investigate this please have all the departments talk to each other. To see well, you know, in five different departments, you've had unexplained symptoms. It's like sit down and talk and, you know, put your heads together."

Theme 5: Supportive Factors

The final theme that emerged from Aoife's interview was the factors that were helpful to her healing journey. Firstly, Aoife's resilience in the face of her abuse and post-abuse experiences with healthcare services is very apparent. Like Niamh, Aoife was eager to contribute to this study in hopes of bettering the experiences of other survivors of CSA, knowing that she would receive no direct benefit from doing so. Additionally, her resilience manifests in her perseverance when advocating for her health despite decades of poor experience and treatment in healthcare settings, and in her noticeable will to move forward with her life and relationships.

Family support played a major role in Aoife's recovery process, despite her parents' initial failings when it came to disclosure. As discussed earlier, she is grateful for their decision to send her to therapy and provide her with the necessary medical help after the abuse was uncovered. This is a notable contrast from Niamh's experience, and may relate to why social isolation/the feeling of 'alien-ness' was not very prevalent in Aoife's experience.

Aoife's personal drive and resilience have been aided and further developed by the therapeutic journey she has been through since adolescence, but more specifically through her work with her CSA-specific psychologist at the clinic. In another departure from Niamh's experience, all of Aoife's therapists since childhood were aware of her history of CSA (which was not the case for Niamh until 10 years ago). However, this detail seems to make little difference to Aoife's day-to-day functioning or level of shame, as both she and Niamh deal with intrusive and disorienting emotions related to the abuse, in a variety of settings.

Aoife mentions that general talk therapy and medication were helpful to a certain extent, but that the addition of eye-movement desensitisation and reprocessing (EMDR) therapy was quite beneficial:

"With EMDR, because I've been doing talk therapy since I was 13, which wasn't really going anywhere, it [EMDR] is possibly the most effective, it's the most effective at

connecting me to myself and what happens. But it is still quite difficult. Because you're stirring up all this old stuff."

EMDR was introduced to her by therapists at the clinic described in the methods section (the recruitment site for this study); in recent years it has gained popularity in the realm of trauma-focused therapies, and is increasingly used with clients experiencing PTSD. Unlike Niamh, Aoife did not talk about her therapists using CFT/ACT or any other compassion-focused approaches specifically, but from the information gathered via interviews with clinicians at the present clinic (elaborated below), it is clear that compassionate and holistic approaches are utilised by all their clinicians regardless of which specific therapeutic modality (such as CBT or EMDR) the therapist chooses. Finally, another interesting difference between the two survivors, is that while art was an important medium of expression for Niamh, Aoife does not mention engaging in creative activities at all, which highlights the need for highly individualised interventions and attentive care for survivors.

4.3.2 Themes Identified in Service Provider Interviews

The interviews with service providers (two psychologists and one staff member working with a service that provides support to migrant women) affirmed the themes found in the survivor interviews, and provided some additional context to their experiences. The psychologists (pseudonyms Marianne and Emily) identified several of the same themes that were seen in the survivor interviews, but also offered unique insights and patterns observed from a more long-term perspective. The interview with Stephanie (pseudonym), the staff member working with a service providing support to migrant women, additionally highlighted an interesting aspect of shame in survivors of FGM, and how their experience of FGM and its consequences can change drastically from their country of origin to their country of reception.

4.3.2.1 Service Provider Backgrounds

In order to ensure the anonymity of Service Provider participants, very limited information is given on their background. Whilst this may limit readers' ability to interpret the results, data protection

concerns had to be prioritised. Marianne and Emily were both woman psychologists working in Ireland, with extensive experience of working therapeutically with adult survivors of CSA . Stephanie is a professional who works as part of a service that provides support to migrant women.

4.3.2.2 Themes That Triangulated with Survivor Accounts

Theme 1: All-Encompassing Nature of Shame and People-Pleasing

When asked about how they viewed manifestations of shame in their clients, both clinicians referred to a pattern of the all-encompassing nature of shame in their clients, and highlighted the developmental ‘rupture’ it causes in their identities and their perceptions of their relationships with others. Furthermore, a related phenomenon that Emily has noticed in her clients, is that they often take on some of the personality traits of their abusers—in particular, aggressiveness towards themselves:

“I think it's the developmental trauma. So I think it's the context in which the sexual violence happened often points to the kind of very early ruptures around attachment”

-Marianne

“I think they can take on characteristics of the perpetrator. Because there's a harshness through there and not caring about this person [self] in that, and it allows them to treat themselves really, really badly. And I think it comes from really feeling like they're at fault. There's a flaw they're so ashamed that of course it has to be their fault. So they take on the characteristic of hurting themselves by language and, you know, the way they treat themselves.” -Emily

These observations echo the experiences of Niamh, Aoife, and countless other survivors, as outlined in Chapter 1. The added perspective that the clinicians provide to this behaviour is extremely valuable as well. While the survivors interviewed saw this kind of aggressive self-talk as yet another ‘failing’ of their selves and proof of their inability to let go of their shame, from the

clinicians' perspective, it is an embodiment of their abuser, and nothing to do with the core selves of the survivors. Moreover, the clinicians point out an element of guilt in the survivors (when Emily mentions *fault*, for example), that also reflects what came out of the survivor interviews regarding guilt and self-blame.

The clinicians also validated the experiences of survivors when it came to people-pleasing, explaining that this kind of behaviour can often be very prominent at the beginning of the therapeutic journey (and if not people-pleasing, defensiveness or aggression towards the therapist):

"You tend to get either the compliance or the defensive, more aggressive. And I would say both of those are really, really common, maybe compliance is more common, but it certainly presents as, as you say, people-pleasing: not saying how they really feel or think. And part of the work of working with shame is allowing somebody to find a voice, allowing somebody to know that it's okay to make a mistake, or it's okay to say something, you know, that maybe is difficult to say or that they don't agree with you."

-Emily

Emily's use of the word *compliance* to describe what the interviewer called *people-pleasing* is a crucial insight into the potential reasons behind this behaviour as well: it is likely that many survivors learned that a freezing or fawning response (i.e. compliance) during their abuse (rather than resisting or fighting back) might have led to less severe abuse (and would have avoided punishment for resisting), and this behaviour eventually bled into their relationships with other people even when those people were not a threat. Gently encouraging survivors to (literally) voice their thoughts and feelings is an important tool for the clinicians with regard to this, as survivors who display compliance or people-pleasing behaviour may find it quite distressing to do (potentially heightening cortisol levels, which could lead to a cascade of other negative psychosocial outcomes in the short term).

Theme 2: Shame and Disclosure in Clients

When it came to the topic of disclosure, the clinician interviews revealed similar themes to the survivor interviews. Namely, that disclosure is one of the first major steps to releasing shame, but that previous negative experiences of disclosure (which trigger shame), are huge barriers for survivors:

“I think, you know, disclosure can be very healing or very harming. Because I think, you know, you hear absolute horror stories of people disclosing and, you know, them almost being blamed or actually being blamed for the abuse. So that, of course, that just compounds the shame.” -Marianne

“I think the very first disclosure is incredibly important. And it sets up, I think it sets it up for every other disclosure. So if a disclosure is treated well, and the client feels it was the right thing to do, then that follows on and a lot of shame can be taken away in those moments. If it's cheap, if it's done badly, or received badly, I think it can set up a client to never speak then. So I think disclosure is hugely, hugely important. And I think a lot of the time, handled really, really badly.” -Emily

The clinicians' testimonies together with the survivor experiences illustrate a major societal- and community-level failing when it comes to handling disclosures, which still needs to be addressed. Cultural factors (discussed below) around conflict avoidance and discussions on topics considered taboo, seem to be at the source of this. The clinicians also cite the need for more trauma- and CSA-specific training for all counselling professionals, as currently, most survivors' first encounters with psychological services (usually not specialised CSA care) do not seem to be conducive to positive disclosure experiences, or to fostering comfort in survivors.

On a related note, Marianne also questions whether aspects of stricter child protection legislation and mandated reporting make it harder for survivors (especially when they are still children) to come forward and disclose:

“Because you've got this terrified person saying this really scary thing. And then if you jump up as a healthcare provider, and think, ‘oh, you know, so I know the notification has to happen’, but just around being able to contain that, and you know, not panic and not panic that person.” -Marianne

Here Marianne brings up a good point— that while mandated reporting is of course a big step forward in getting victims the help they need and in preventing abusers from victimising further, the possibility of a panicked or uncomfortable reaction from the professional (doctor, psychologist, etc.) may be inhibiting many from disclosing at all. Furthermore, in cases where the abuser is still alive, the survivor may not be ready to face the legal processes that come with reporting (which would be mandatory if disclosed to a professional). However, as evidenced in Aoife’s account, *not* disclosing in this scenario could further exacerbate guilt and shame, by making the survivor feel at fault for ‘allowing’ the abuser to continue abusing others. This frustrating conundrum highlights how insidious, toxic, and inescapable CSA-related shame and its resulting emotions can feel once planted.

Theme 3: Self-Doubt

Another major survivor theme that Marianne has also observed, is heightened self-doubt in survivors: *“Yeah, that's another thing. Doubt, lots of self doubt. Especially relating to their memories and that kind of stuff.”* She goes on to say that over the years, she has noticed that clients who start to let go of some of their shame, also start to exhibit less self-doubt, manifested in things like:

“One example might be that, like, if they're not double checking, without every conversation, they're much more trusting of themselves and their positions and their views, you know, they don't have the same levels of self doubt, they're able to accept their feelings.”

This observation somewhat ties into previous research findings, discussed in Chapter 2 and 3, which link difficulties with emotion regulation (potentially manifesting in the inability to accept contradictory or uncomfortable feelings), and CSA. Marianne's comment references self-doubt relating to their memories, which, once again, reflects the experiences of the survivors in this study.

Theme 4: Dissociation

A final theme explicitly reflected in both the survivor and clinician interviews, is the commonality of dissociative tendencies in survivors:

"Dissociation is huge. And I, you can see it, you know, when you touch on something uncomfortable, you can actually see the client, almost leave the room, you know, or go somewhere else [mentally]." -Emily

The type of dissociation described here mirrors that described by Niamh earlier; in the following section clinical tools used to aid clients when this happens are discussed.

4.3.2.3 Unique Insights from Service Provider Interviews

In addition to the triangulation of major themes in the survivor interviews, the clinician interviews also provided a few uniquely relevant insights into shame, which are detailed in the section below.

Theme 1: Unique Clinical Insights

One of the most interesting points of discussion in the interview with Emily, was whether it was useful to clients to aim to fully rid themselves of shame. Emily mentions that in her practice, her goal is not for her clients to completely release shame, but rather just bring their shame down to 'non-toxic' levels:

"I think it's really important that we never try to get rid of shame entirely. We want to bring shame back to a normal level, and not make it chronic and toxic. But it's really important, because I think sometimes clients think if they give up shame, that they're actually like their perpetrator: they're shameless."

As discussed in Chapter 1, shame does occupy an integral space in society, helping aid social cohesion in the long term despite causing pain on an individual level in the short term. Of course, this specifically applies to typical, or non-toxic/chronic shame, which is Emily's goal when working with survivors. It is interesting that over the course of years of therapy, survivors seem to move from embodying their abusers in various ways (carrying the blame for the abuse, feeling at fault, aggressive self-talk, etc.) to being confident enough to express their desire to reject characteristics they associate with the abusers, such as shamelessness; this is a testament to the therapeutic processes being utilised by specialists such as Emily, as well as to the survivors' resilience and determination.

When it came to differences in the behaviours of male and female clients, Marianne had not noticed any major divergence between these two genders. When asked if she approached male clients in a different way, she said:

"To be honest, no, because they're so different, like, each individual is so different. I used to think before I worked with [clinic] that it might be, like when I was, for example training...you think men might be different at times....So I'm not saying that's not there. But I find individual people are so much more different from each other. So you could have, you know, a woman who finds it very hard to, you know, connect with her emotions. And I found, you know, and it was considered that kind of more masculine way...and then you could have a man who just comes in and just cries for a whole session. So the gender thing, for me, just, I just haven't found it reflected in my practice."

While she does acknowledge that she might be overlooking something, overall Marianne sees more individual-level differences in her clients than gender-level differences. She also mentions that rather than survivor gender being significant in any way, she has observed patterns relating to the influence that the perpetrator's gender has on survivors:

"Maybe it's because women's bodies are different, obviously to men's and there's like an interior, and obviously men don't have an interior in their bodies..And I often feel clients who are abused by women are really claustrophobic. You know, there's this palpable kind of claustrophobic sense that they have, as part of the impact....I know, it's a huge generalisation. But you know, for men, when they offend, when they perpetrate, it's often about the sexual act itself. Like that's the thing, you know, whereas I think women have a much more complicated fantasy about the child. And it's often quite early abuse, sometimes it's mothers."

The 'interiorness' of a female perpetrator, referring to the vaginal canal, seems to make the survivor feel like they are being consumed—this combined with the more complex fantasies that Marianne talks about, may feel much more all-encompassing or all-consuming to the survivor, than a male perpetrator abusing without the use of those fantasies and stories. In the case of the abuser being the mother, the abuse may be accompanied by an even stronger sense of betrayal and disgust, as traditionally the majority of caregiver responsibility fell on the mother, and this expectation is completely shattered if the mother sexually abuses the child.

Continuing this conversation, Marianne further elaborated on the differing consequences of male and female perpetrators:

"If you have a teenage boy, for example, he's been abused by an adult woman, it's like, well, you know, it's nearly like they are to be looked at to be lucky or something."

This quote is particularly interesting, as it contradicts what Marianne had said earlier in the interview regarding noticing differences in survivors of different genders—the conversation about female perpetrators itself seems to hint at a very different sort of abuser-victim relationship depending on the genders of both the abuser and the victim, and her observation of how male victims are sometimes treated or expected to react seems to support that.

Male experiences of CSA are also discussed in Chapter 2, and the societal expectations of male survivors, such as the ones described in the quote above, are a major contributor to their

shame. Furthermore, while abuser gender is an important factor, it inevitably interacts with victim gender; the ‘interiority’ of female perpetrators described above is likely even more relevant for male survivors due to the subversion of expected power dynamics (typically men are expected to assert power over women, or assume the ‘penetrative’ role during sexual intercourse), in this scenario. There is likely increased shame for boys abused by women due to having in a way been ‘consumed’ by a woman. Marianne also described the confusion that might be caused in male victims regarding how their bodies react during the abuse:

“So sometimes the body reacts in a very normal way to being touched. And I think, for boys, because of the way their bodies are, and you know, it can be seen that they may be excited, I think there's a terrible kind of betrayal that they can feel around their body.”

This kind of ‘betrayal’ may also lead to a feeling of alienation or dissociation from one’s own body, the kind highlighted in Niamh’s story (when she described wanting to be rid of her vulva). When combined with societal expectations that boys, particularly adolescents, are ‘supposed’ to enjoy sexual attention from women (and sometimes societal disbelief in the fact that boys can be sexually abused), the fact that physical arousal is more evident in male victims can lead to a sense of shame in victims about not feeling good during the abuse, specifically that there is something fundamentally wrong with their masculinity. In cases where the abuser is also male, physical arousal during the abuse could lead to survivors questioning their sexuality, and in communities where homosexuality is not widely accepted, may then lead to sexuality-related shame.

Another area of discussion to which the clinicians provided further insight, is the impact of cultural factors in Ireland on survivors’ post-abuse experiences. One factor that Emily cites as important, is how survivors see other survivors being treated in the media:

“And outside of that, then it can be, you know, like media, or you hear court cases where, you know, people's [the victim's] underwear is being spoken about, or what

were they wearing, or all of these things, plant seeds of who's to blame, and it's genuinely victim blaming."

Corroborating the experiences of both Niamh and Aoife, Emily acknowledges the deeply-entrenched victim-blaming culture in many facets of community—watching survivors be treated with suspicion and disrespect by the legal system would only serve to prevent them from coming forward with their stories. Marianne talks more about cultural attitudes towards conversations about sex and abuse:

"I think Ireland has an absolutely chronic record in terms of like, any kind of healthy discussions around just like health, healthy sex, sexuality, intimacy, relationships. All of those things. And then I think, because we have the Catholicism [aspect], you know, here where like, all things to do with the body and sex were this, like, shameful thing. And even like normal—I don't mean abuse—but just normal sex, like, is considered quite unhealthy. And we're all part of the culture. So it's like you're not outside of your culture."

She also mentions the 'awkwardness' that often permeates conversations involving disclosure of CSA:

"This is probably their biggest secret, the thing they're most terrified of, and what they get is usually like an awkwardness and awkward reaction. And then the worst case of that is, if that awkwardness is so much, it's like, they blame the victim then for disclosing, because 'you're making me feel uncomfortable.'"

In a culture where even having discussions about healthy sexual relationships is found extremely uncomfortable by a lot of people (particularly older generations, who would have been the parents of many survivors the clinic works with), survivors find it extremely difficult to identify spaces in which their abuse and feelings about it would be handled with concern and care, rather than awkwardness and dismissal. In the last line, Marianne also pinpoints a reason (briefly discussed in Chapter 1 in relation to the collective shame that shrouded the nation when clerical

abuse was uncovered) for the discomfort many may have felt in broaching the topic of sexual abuse with survivors—reckoning with the fact that they too were part of the culture of silence that prevented survivors from speaking up may be something people are not ready to accept.

Theme 2: Therapeutic Approaches

In terms of the therapeutic approaches that Marianne and Emily find most effective with their clients, both cite compassion-focused and client-centred approaches as crucial; while they each have their own preferred modality (as mentioned above), ultimately both clinicians utilise a sort of integrative approach with clients. The most important thing for them is to tailor their approach to each client.

One specific way in which Emily begins to address shame in clients, is by bringing the concept of shame into the room early on and explicitly:

“I suppose initially, kind of in the first or second meeting, I will always try to bring the word shame in. So I think once it's in the room, it's really important, because that allows somebody to know that it's okay to talk about shame in this room. Sometimes people won't even use the word shame, they may not even know what the word shame actually means. They may know it as a body feeling as opposed to being a cognitive word.”

In a way the act of naming shame, and having the survivor be face-to-face with it in the room, is an act of subversion and resistance against it, considering that shame thrives in secrecy and in the isolation of the survivor.

Additionally, psychoeducation and grounding exercises can help ease clients into the therapeutic space, allowing them some time to understand what to expect, and to assess if their therapist is a good fit for them at that stage:

“Psychoeducation is probably another really important aspect of the work because people are alienated and isolated, and believe they're the only person who feels this

way or suffers in this way. So psychoeducation and knowing why something happens and what's common is really, really important.” -Emily

“I start working with almost like stabilisation in a sense—psychoeducation. Often people are having, you know, a lot of intrusive symptoms, flashbacks, so kind of using grounding strategies initially, making sure people feel kind of able to manage, I suppose—regulate.” -Marianne

Marianne also utilises ‘body work’ to some extent in her practice:

“Now I would do body work in the usual way of you know, I’d be very good at seeing if someone is like, you know, very tense, if they’re breathing properly, if their jaw, you know—I can read the body in that way. I think to do the body work really, really safely around trauma, you need to have a very specific training in that. One thing we are bringing in for everyone, well, not for everyone but for all the therapists, are changes in neurofeedback.”

Bringing attention to parts of the client’s body which may be storing or expressing shame and discomfort may be necessary with some people, particularly those who may experience more bodily dissociation. Furthermore, the integration of neurofeedback (discussed more in the methods section) could help boost self-awareness and self-regulation when it comes to shame-related thoughts due to the consciousness of thought and feeling required during this technique.

An important technique that Emily uses with some of her clients is ‘parts work’, otherwise known as Internal Family Systems (IFS) therapy (Schwartz & Sweezy, 2019), a modality often used in cases of PTSD. Emily explains her use of the technique here:

“I do a lot of parts work. So working with different parts of a person. So sometimes, if I see this, really, defensiveness come out, or somebody, you know, maybe starts to give you really, maybe quite aggressive, one word answers or, you know, starts to really back away and put some barriers up, you know, sometimes I’ll say: ‘God. You

know, I think there's a part of you there, that feels really uncomfortable right now.'
And you sometimes will break down, what does that part need to trust in this
room....So sometimes we'll call different parts, but it's all it's trying to make the client
accept that there are parts that are frightened. And that those parts generally start
out trying to protect, and sometimes they really get in the way. But it's about bringing
that part in and what would make that part feel safe in this room."

It is clear that compassion is an integral part of the techniques and approaches described above, and an inevitable trait of effective therapy for CSA survivors. The clinicians also emphasise the fact that progress when it comes to releasing shame is extremely slow—and while time-bound therapeutic practices like CBT, CFT, and ACT are no doubt helpful, it takes years of difficult and in-depth therapy incorporating multiple approaches and techniques, for clients to undo years of ingrained shame.

Lastly, when asked what signs they look for that indicate clients are beginning to release their shame, Emily says the following:

"I think when the shame starts to unravel, and the compassion starts to come in, they
can start to feel differently among other things. Other times, it's allowing themselves
to realise how they feel, because sometimes shame stops them actually admitting how
they're feeling. So sometimes people can essentially get a lot worse in the course of
therapy because actually, they will allow themselves to feel how they're actually
feeling, so that depression can sometimes I think, become worse. But it's always in a
sense of, you know, 'I feel like I'm on my knees, but I still feel healthier.' *And that's the*
important thing to look for."

As mentioned in a previous section, change can be seen when survivors are more compassionate towards themselves—and perhaps action, such as talking to themselves using compassionate language during therapy, must in many cases precede the actual feeling of self-compassion in order to get started. Marianne echoes Emily's thoughts:

“And then I think sometimes the person starts to soften towards the memory of themselves...You know, and then I think that shame starts to kind of soften, definitely, and they become much freer and have more capacity for an hour to live and to kind of be more assertive, and, you know, trust themselves. I think the shame is the hardest one to work with of all, it's even harder than, you know, all the intrusive memories, and it's the hardest one, but you're working with it around the boundaries, and so all of that, I think, leads to a really healthy assertiveness: ‘I've been able to say no and not explain [why I said no]’”

In conducive and safe settings, the self-compassion that the survivor gains through their therapeutic journey then can extend not only to their present selves, but also to the child that they were. They are eventually able to be the compassionate, caring, and protective force for their past selves that they did not have in actuality.

4.3.2.4 Themes in the Migrant Women's Health Staff Member Interview

Through her role in the service, Stephanie has years of experience working with migrant women who have undergone FGM and/or other forms of CSA including forced and early marriage. This experience has allowed her to observe broader patterns of how those with FGM and abuse histories experience shame in different contexts. Firstly, Stephanie's observations of survivors of FGM and/or early and forced marriage to a large extent triangulate with Marianne and Emily's perspectives. She cites survivors having trouble with disclosure of FGM due to shame, shaming by community members (both in the country of origin and in Ireland) for so-called abnormalities in the survivors' bodies or moral character, guilt for potentially subjecting their own daughters to FGM (as it sometimes occurs against the mother's will), and the embodiment and influence of shame in their everyday lives.

One of the major unique insights Stephanie provided, is her observation that some women with FGM histories who arrive in Ireland (or other receiving countries in the Global North,

often as asylum seekers or refugees) may not initially feel negatively about having been subjected to the practice, as it may be very normalised in their countries of origin:

“For example, where rape is very common, even where FGM is very common, people will not look at this as something which is illegal or a crime until maybe they come to a place like Ireland and maybe the centres they are in they see people are going there with our [the service’s] leaflets saying ‘Stop FGM’ or saying things about sexual and reproductive health, maybe talking about female condoms, bodily autonomy, and other things. That’s when people might be like, ‘Oh, my God, I never thought that this was something maybe which was done to me and it was not right.’....Because especially in Ireland, women who have gone through FGM are in a minority, whereas in their own countries, let’s say, a place like Somalia or Guinea or Sierra Leone or Djibouti, they are in the majority. Here, they become a minority.”

The process of migration for those with FGM histories not only results in its normal trauma, but might also exacerbate shame when women are suddenly faced with an abundance of information in healthcare or other settings telling them that what they went through was not normal. Inevitably this signals to the women that *they* are not ‘normal’, that there is something fundamentally ‘wrong’ with their bodies—again, a core facet of shame.

Even referring to them as FGM *victims* or *survivors* at this initial stage may serve to alienate them, as this is likely not at all how they see themselves. So while ultimately it is beneficial to provide all women arriving in Ireland with this kind of information on FGM and related support services, a review and potential revamping of methods of doing so is clearly needed in order to avoid instilling shame in those with FGM histories where there may have been little to none before. Furthermore, anti-FGM campaigning in countries of reception must ensure that it is not pushing survivors away by inadvertently deriding their countries/communities of origin—communications must be culturally sensitive, and ideally come from people within those communities. A major

hurdle in achieving this type of communication is a lack of resources for and awareness of FGM in Ireland.

As a result of the accompanying shame (be it from before or after they arrive in Ireland), many women with FGM histories find themselves isolated and further hiding into themselves when they arrive:

“And you can see that they also get very anxious when they are going to the gym, they get very anxious when they have to go to see a gynaecologist or maybe it's time for them to have a baby. Because they are so so worried about what people are going to think when they see how their bodies look. So that shame and then being in the minority, it also can cause isolation...And it can make you react the same way, not wanting to mix with people, not to talk about it and all that, and even not, and even seek services.”

Part of the reason many women feel the need to isolate themselves in light of their shame, is undoubtedly the living conditions in which asylum seekers are placed for months or even years after they arrive—as the Direct Provision programme often assigns living spaces at random, women may be living in close quarters with those from completely different parts of the world, making it difficult for them to form a community in which they can openly discuss their FGM experiences or ask for support.

Another interesting point of discussion, and one that maps onto the clinician's perspectives on clients, is how Stephanie sees the progression of women who come to the service needing help with physical or mental health issues relating to their FGM:

“When you have a big meeting for [the service], where we're talking about FGM and someone [a client] is in the programme to talk about her personal experience, let's say we are launching [a handbook], and someone is sent to stand there as a person who has gone through that—that's huge. That's a very, very huge step.”

As some of the fundamental traits of shame involve hiding and avoidant behaviours, and shame itself seems to thrive in ‘darkness’, so to speak (in the isolation of survivors and their avoidance of bringing forth their experiences and emotions out into the open), the act of standing up, being exposed to others, and speaking about their experience helps mitigate some of their shame.

Finally, according to Stephanie, an important part of dealing with shame and shaming culture in relation to FGM, is ramping up training and awareness campaigns around the country. She describes the extremely uncomfortable experience of a client who received treatment for her FGM:

“One case comes to mind about a woman who came to us, and, after going through the journey with her, she was ready for an intervention in [hospital in Ireland] to restore her anatomy to some form of normalcy so that she can have a pleasurable sexual experience. And when that woman went to the hospital she was sorted the same day. She had the operation, she was discharged in the evening. And I remember going to meet her and she couldn't walk, and I remember I went to do a lot of things in between to ensure that she got somewhere to sleep because she had come all the way from a DP [Direct Provision Centre] in [County Cork]. And it was winter.”

As it stands, there is no mandated training in medicine, or nursing and midwifery degrees in Ireland relating to dealing with FGM in patients—while FGM may have been an extremely rare phenomenon in the country for most of its history, at the moment there is a large influx of women with FGM histories, many of whom will give birth in Ireland, and many of whom have severe complications from FGM (such as FGM type 3). The lack of training and awareness of the various medical complications around FGM, combined with the lack of general public knowledge around the Direct Provision system and its consequences (such as recent arrivals living in rural areas, lacking access to FGM-specific medical services and transport), have led to situations like the one described above. Like Marianne and Emily, Stephanie stresses the importance of compassionate

and client-led care at all levels of healthcare service, from the moment of contact with service providers such as herself, to contact with healthcare professionals and legislators as applicable.

In the last decade, FGM-related campaigns and a few specialised health services have been funded by national bodies like the HSE, and this service in particular has been awarded funding to implement some of the HSE's goals around FGM. However, the quantity and geographical distribution of these services is still lacking, and FGM as a cause suffers from the same obstacles nearly all medical and mental health causes do—general lack of healthcare funding, consequent difficulty in staff recruitment, overburdening of healthcare services, and barriers for patients to access services (lack of public transportation, etc.). Dealing with FGM- and CSA-related shame and tackling the current funding and staffing crisis in the Irish healthcare sector therefore go hand-in-hand; without the latter, regardless of how much public awareness or legislation there is on FGM, appropriate and timely care to survivors will not be achieved.

4.3.3 Evaluation of Analysis and Reflective Considerations

As part of the analytic process, the following steps were taken to ensure that the data reported are as reliable and credible as feasible given the ethical boundaries of the study. These steps were based on Lincoln and Guba's (1985) criteria for evaluating qualitative research (credibility, transferability, dependability, confirmability).

First, in order to establish credibility, the following steps were taken: 1) Prolonged and persistent engagement: The lead researcher was the primary analyst of the interviews, and engaged deeply with the interviews over several months. The IPA method and case study approach used in this study also lent itself to a richer understanding of the material; 2) Triangulation: Methods triangulation was achieved by complementing the current, qualitative study, with the quantitative study of Chapter 3, details of which are discussed below. Source triangulation was achieved by interviewing survivors, clinicians, and a social service provider, thereby collecting data on the same topic from multiple interrelated perspectives. Analyst triangulation was achieved by conducting weekly analysis consultation meetings with one of the

project supervisors over the course of two months, in order to co-analyse and review the lead researcher's thematic findings; 3) Peer debriefing: the second project supervisor was brought in post-analyst triangulation sessions in order to review findings.

Next, for transferability, the following steps were taken: 1) Thick description: descriptive quotes were used throughout the results section to illustrate analytic points being made and general themes. These quotes also often provide detailed contextual information. It is important to note though, that the aim of the study was not to produce generalisable themes, as the target population was quite specific and small.

Finally, to establish some confirmability, the following steps were taken: 1) Triangulation: as described above, methods, source, and analyst triangulation were utilised; 2) Reflexivity: Through the analysis process, the lead researcher reflected on her own potential biases, how her background and other characteristics might be impacting the analysis, and what implications she might be overlooking due to not being a member of the same communities as the interviewees. In order to help mitigate bias in the analysis, the lead researcher read a wide range of literature on CSA, FGM, and shame, both as part of the systematic review portion, and outside its scope (including books on shame and CSA). As an additional method of reflexivity, this study will be submitted for publication in a peer-reviewed journal in the near future, garnering additional viewpoints and critiques on the analysis. However, the lead researcher acknowledges that as she does not have the lived experience of the survivors or service providers, there will always be a gap in understanding exactly what their narrated experiences and their day-to-day lives feel like.

4.4 Discussion

This study aimed to gather rich, in-depth information from Irish CSA survivors regarding their experiences of shame, and to explore how/if these accounts triangulated with patterns observed by clinicians in a CSA counselling service, and a service provider working at a service supporting migrant women. This was done in order to describe some of the main ways in which shame in the context of CSA manifests and evolves within specific populations of survivors (Irish CSA survivors

and migrant FGM survivors). The study is the first to my knowledge to deeply engage in qualitative research on CSA-specific shame in adults in Ireland, as well as to attempt shine a light on the increasing phenomenon of FGM (and its resulting shame) in Ireland. This study also aimed to complement the quantitative research conducted in Chapter 3; as such, connections between the findings of the two are highlighted in the next section. A range of themes from these sets of interviews was identified and elaborated on in the results section above. Implications of these findings are discussed below, as are suggestions for community-level, structural-level, and clinical-level amendments to prevent the development of toxic shame in survivors.

4.4.1 *Support for and Elaboration of Quantitative Results of Chapter 3*

The data provided by the in-depth interviews support and expand on some of the findings of the quantitative study in Chapter 3. Firstly, this study supports Chapter 3's finding of a significant (negative) relationship between self-compassion and CSA-related shame. This was seen in the survivor interviews, but more clearly stated by the clinicians. In short, the more self-compassion survivors are able to actively exercise, the fewer shame-related behaviours (such as hiding and aggressive self-talk) they seem to display. Further, acts of self-compassion such as a softening towards the self and the past self, are key indicators to clinicians that breakthroughs in a survivor's therapeutic journey are being made.

The interviews reveal that the acquisition of self-compassion is a very gradual process, and the trajectory of increasing self-compassion is often not linear—in fact, setbacks are sometimes a necessary part of the healing process. This finding is important to keep in mind when collecting quantitative data on self-compassion and shame, particularly if this is being done in a clinical setting to assess progress—a non-significant relationship between the two may not necessarily mean that interventions are not working.

The second finding of Chapter 3, which this study seems to support on the surface, is that the amount of time someone has spent in therapy does not seem to correlate with their current levels of shame. The two survivors interviewed, despite having been in CSA-specific therapy for

over a decade, are still affected by their shame on a day-to-day level. While they are able to recognise and articulate the pitfalls of this shame, and express (at least verbally) that there is nothing about themselves to be ashamed of, they acknowledge that it is very difficult for them to apply this intellectual understanding to their lives, and are often still swayed by their inner shaming voice.

This is not to say that CSA-specific therapy has not reduced their overall level of CSA-related shame. It is clear that it has, and their day-to-day life likely is affected *less* by shame today compared to when they first started attending the clinic. This is also corroborated by the clinicians, who mentioned the commonality of gradual behavioural and linguistic changes in survivors, and how these signal to them that their clients' shame is reducing.

Instead, in light of the qualitative data, Chapter 3's finding of a lack of correlation between time in therapy and shame levels could be interpreted as, a) confirmation that CSA survivors, as a subset of trauma survivors, have unique shame signatures in that they already start off with extremely high levels of shame which reduce only slightly (by the standards of the scale being used) over several years—this change may not be registered by the TRSI for instance; and, b) the shame measure that was used in Chapter 3 (the TRSI), being a measure for general trauma-related shame, was not designed to capture important facets of CSA-related shame such as the aforementioned behavioural and linguistic signs of reduced shame, which are incredibly important and telling for clinicians in particular. This points to the need for a dedicated, and multi-modal measure of shame for the CSA context.

4.4.2 *Major Takeaways and Suggestions for Shame-Reduction Approaches*

Despite the small sample size of this study, the interviews with survivors and service providers are rich in detail and reveal a wealth of vital information about the role of shame in CSA survivors' lives. In addition to the themes explored above, and the elaboration of quantitative results from Chapter 3, the interviews also provided some general takeaways, described below.

Firstly, the survivor accounts support Finkelhor and Browne's (1985) traumagenic model of CSA; the experiences described in the interviews clearly illustrate the four traumagenic dynamics laid out in the model: 1) traumatic sexualisation, 2) betrayal, 3) powerlessness, and 4) stigmatisation. Betrayal and disempowerment seem to have been the predominant dynamics in the survivors' childhoods, with powerlessness is a major theme in their adulthoods.

The usefulness of shame measures within the context of clinical intake sessions is supported by the survivor interviews. Going by what the survivors suggested regarding the use of shame measures, adding a few questions about general shame, guilt, and bodily shame onto an intake form may signal to survivors coming into a clinic or other service that the staff in the service are open to and capable of dealing with potential CSA disclosures. It is crucial for all mental health and medical services (not just sexual abuse-specific ones), to incorporate these questions on their intake forms, as the first point of contact survivors generally have is with these generalised services—this is an opportunity for services to offer survivors a safe and shame-free space to disclose their abuse if they are ready to do so.

As evidenced by previous research (Alaggia et al., 2019; Boakye, 2009; Collin-Vézina et al., 2015; Crisma et al., 2004; Gagnier & Collin-Vézina, 2016; McElvaney et al., 2014) and as discussed in Chapter 2, the act of disclosure is a crucial part of the healing process that can aid with the release of shame to some extent, since (as mentioned in the results section) shame thrives in secrecy and silence. Therefore the sooner survivors are enabled to disclose, the better their shame-related outcomes are likely to be, and simple steps like adding one or two screening questions relating to shame and/or CSA may go a long way.

An example of this concept being rolled out in Ireland at the moment is found in Stephanie's (the staff member who works with migrant women) work with maternity hospitals around the country—in collaboration with the hospitals, Stephanie has had a simple question regarding FGM history incorporated into intake forms at all maternity hospitals. Not only does the

question allow women to disclose the FGM discreetly (as it can be overwhelming to verbalise this), but it also holds healthcare professionals accountable for handling these types of disclosures appropriately (for which they may be required to undergo training, further improving the level of care FGM survivors will eventually receive).

Another major takeaway reinforced by the interviews, is that long-standing systemic failures and cultural developments since the time of participants' experiences with CSA further complicate the landscape of support and recognition for survivors over a certain age. Historical reluctance to believe survivors (highlighted in Chapter 1), combined with inadequate legal and social support systems in the past and present, reflects a broader cultural failure to prioritise the welfare of children and survivors. In fact, the survivor interviews in this study provide a damning illustration of the callousness and disregard of many of the healthcare and education professionals with whom the survivors crossed paths in the 80s and 90s. It is likely that this was due to a combination of time constraints, a lack of training on handling suspicions and disclosures of CSA (exacerbated by the lack of mandated reporting at the time), and a general lack of awareness about the prevalence of CSA. In hindsight it is clear that these kinds of widespread structural issues and lack of clarity regarding child abuse legislation, led to a professional culture of absolving oneself of the responsibility to act and follow up on suspected (or even disclosed) CSA.

Despite progress having been made at the legislative level in recent years (such as the introduction of the Children First Act 2015), there is often a lack of appropriate mechanisms and training when it comes to identifying and responding to signs of abuse, leading to missed opportunities for intervention and support. This is largely down to historical underfunding of the Irish healthcare system and particularly severe budget cuts that were implemented in the wake of the 2008 financial crisis (Turner, 2018). The healthcare system has only recently begun to recover from the structural consequences caused by this underfunding, meaning that tangible change to service provision and speed of care will lag behind any budget increases that the Department of

Health receives for several more years to come, if staff compensation and training models are not drastically changed. Moreover, the department currently struggles to recruit Irish-trained nurses and doctors despite having the highest number of medical graduates per capita in the EU (as so many medical graduates are international students; the problem of medical staffing difficulties then also extends to immigration policy issues in the Department of Justice) (OECD & Policies, 2023).

Furthermore, mental health spending accounts for only 5.8% (€1.3 billion) of the total healthcare budget for 2024 (€22.5 billion) (Department of Health, 2023)--and this is the highest proportion to date. Demand for psychological support in the areas of child and adolescent mental health, and children's disability, are at an all-time high, but rates of service provision and geographical spread have not caught up (Mental Health Reform Ireland, 2023; The Psychological Society of Ireland, 2022). Lastly, another major bottleneck in effective service provision in the Irish mental health sector is the underfunding of professional training avenues for mental health workers. In 2022 there was an estimated shortage of at least 322 psychologists in the country (the true figure is likely more), yet only 100 psychologists enter professional training programmes each year, in large part due to the lack of a living wage during training, and having to pay tuition fees on top of that (The Psychological Society of Ireland, 2022). Given the current state of mental health services, it is unlikely that the needs of children experiencing sexual abuse are being properly met. While survivors' acute mental and physical health care needs may be met, the system does not have the space to address things like mitigating the shame that these children are developing.

The situation for children from migrant backgrounds, and women with FGM histories, is hence even more dire, given the potential language barriers (and lack of widespread translation services), the unfamiliarity of healthcare staff with FGM and its outcomes, and the difficulty many migrants in Direct Provision find in reaching hospitals and clinics.

The role of societal norms in perpetuating the silencing and shaming of survivors (such as family honour) cannot be discounted when trying to understand how shame is instilled in victims of CSA, and why perpetrators are often not held accountable. Addressing these cultural factors requires comprehensive cultural reforms, including general population-level educational campaigns on the signs and impacts of CSA, and on how the words and actions of family and community members might be inadvertently shaming survivors.

Another area for socio-cultural intervention could be educational campaigns such as ads and social media posts highlighting statistics about interfamilial CSA. In both the survivors' stories, family and other community members were initially reluctant to accept the possibility of a relative committing CSA. While this is understandable, it ultimately scars survivors for life, contributing immensely to long-term self-doubt. Targeting this specific phenomenon gently but directly would be another small step in changing the culture and conversations around CSA, thereby eventually reducing the amount of shame survivors are made to feel from childhood—it is important to make sure that such campaigns are careful in their wording however, as the language used may inadvertently promote shame.

Similarly in relation to FGM, culturally sensitive and carefully worded public awareness campaigns must be created. More importantly though, medical training on FGM must be made mandatory in order to ensure equal care for FGM survivors across the country. At the moment, Stephanie and another staff member at the service supporting migrant women provide one-off lectures on FGM to nursing and midwifery students around Ireland, however these lectures are not an established part of these courses, and Stephanie is invited to conduct them at the discretion of each course director. Consequently, some nursing students go on to practise with the ability to work with FGM survivors, while others practise not being aware of FGM at all.

As elaborated on in the results section and in Chapters 1 and 2, compassion-focused therapy (CFT; Gilbert, 2009) provides some useful tools to clinicians for untangling the shame of

survivors during therapy when combined with other approaches such as psychoeducation, CBT, EMDR, and more. When used within the context of long-term, trauma-informed therapy, incorporating specific tools from CFT seems to have a positive impact on survivors' confidence and self-esteem, and empowers them to reframe their narratives in a less self-judgmental and brutal manner. This is clearly seen in the way Niamh and Aoife talk about their experiences after years of compassion-focused counselling. Previous research also supports the use of elements of CFT or elements of it with CSA survivors (Bowyer et al., 2014; Hamrick & Owens, 2019; McLean et al., 2018; Olson & Walsh, 2024). However, in Niamh's case, it seems that compassion-centred approaches alone were not enough to encourage disclosure. This is something clinicians (CSA-specific or otherwise) may want to keep in mind, namely that compassion-focused approaches might overwhelm survivors at the start, perhaps even making them distrustful of the therapist if they have not been treated with that level of compassion before, or if their abuser wielded compassion in some way to groom them.

Other potential therapeutic approaches that show some promise in the area are Internal family systems (IFS; Schwartz & Sweezy, 2019) therapy and neurofeedback (Evans et al., 2019). IFS is based on the view that the mind is composed of discrete parts or personalities that represent different perspectives, and that these parts feed into the person's core self. It also involves elements of self-compassion, perhaps making it more suitable to CSA survivors and survivors of other kinds of sexual violence. During a therapy session, the client may be asked to embody one or more of these parts and to speak to another part, or perhaps to the core self. IFS has already been shown to have some efficacy in and utility for survivors of CSA (Hodgdon et al., 2022; this study demonstrated significant decreases in PTSD symptoms post-intervention, with a medium effect size), but research on this is still quite sparse, indicating that this is an important avenue for further research.

Similarly, while there are a number of studies and systematic reviews pointing to moderate effectiveness of neurofeedback on people with PTSD, studies of this technique in CSA survivors are much fewer. Neurofeedback is a type of biofeedback practice by which (usually) an electroencephalogram (EEG) is attached to the person's head, and they are able to watch their own brain waves in real time while being guided on their train of thought. A recent systematic review (Chiba et al., 2019) studied the effectiveness of a subtype of neurofeedback (decoded neurofeedback) on people with PTSD, and concluded that while research on this subtype is still in its infancy, existing research offers promising results in those with PTSD. Another systematic review (Panisch & Hai, 2020) on the effectiveness of general neurofeedback in improving behavioural outcomes in people with PTSD found that research in this area is inconsistent in study design, outcome measure, and sample size, thus making it difficult to assess the how effective neurofeedback actually is. Further, yet another review (Schutz & Herbert, 2023) looked at evidence for neurofeedback training in children with traumatic experiences, concluding, like Panisch and Hai (2020), that there is too small a selection of studies in this area to come to a consensus on effectiveness despite one or two studies showing promising results.

Lastly, expression through art plays a significant role in the healing journey of many survivors, as exemplified in Niamh's story. A recent thematic analysis of studies (Laird & Mulvihill, 2022) has shown beneficial outcomes of different types of art therapies in survivors of sexual abuse, with improvements seen in survivor-clinician rapport, and anxiety, PTSD, and dissociation symptoms. Art, whether in the form of painting, writing, music, or other media, offers a powerful outlet for expressing emotions and thoughts that might be difficult to articulate verbally, or that survivors might feel are taboo to bring up during talk therapy. The process of creating art can be therapeutic in itself, allowing survivors to externalise their shame in a very literal way, in a safe and controlled environment. This link to art therapy highlights the importance of creative expression in facilitating emotional processing and self-discovery, the latter being fundamental to redefining a survivor's identity into something more positive and distinct from their shame.

In sum, addressing shame in the aftermath of CSA requires a multipronged approach, but one that prioritises reducing the impact of systemic and cultural factors in the development of shame in childhood. While therapeutic approaches are certainly crucial to survivors' healing, in order to prevent shame from setting in at all, there must be a much larger focus on external, societal contributors to survivors' shame—as evidenced in this study, the consistent presence of these factors throughout the survivors' lives (such as the reactions of people and institutions of authority around the victim during and after the abuse, as well as messaging around CSA seen in the media, among many other things) is the driving force behind their deep-seated shame, after the actual abuse. Therefore by shaping society to be less shame-inducing to begin with, there is hope for survivors to reconstruct their narratives at a much earlier stage in their lives.

4.4.3 Limitations

While this study offers valuable and detailed insights into survivor and service provider experiences, it suffers from some limitations that preclude the data from being more diverse and generalisable. The majority of these are a result of necessary constraints of the ethics process, time, and resource shortfalls of a PhD programme.

4.4.3.1 Limited Scope for Recruitment. Firstly, participant recruitment for survivor interviews was limited to one psychological clinic, which greatly curtailed the number of potential participants the study could have recruited. The researchers were also required to use a gatekeeper to recruit participants rather than having the lead researcher be directly involved in recruitment.

The inability to recruit survivors from other mental health services, community samples, or the general public meant that the survivor population sampled in the study is very specific, and results could not be generalised to the larger population (although they provide support for much of the existing qualitative research on shame and CSA). The ethnic and cultural diversity of participants was also affected by this constraint, as certain ethnic or cultural groups may frequent different 'go-to' services than the clinic in this study. As a result, this study was not able to

compare and contrast perspectives of the two white Irish women interviewed with those of survivors from very different backgrounds.

Recruitment of survivors from the service supporting migrant women, for example, would have been ideal. However, this was not feasible, as the ethics process required participants to be presently engaged in therapy, something that was not likely for clients of the service. Resources were also not available to hire a stand-by clinician for the duration of the interview. Moreover, survivors who have never engaged in therapy could not be recruited, resulting in a lack of this very important perspective.

Discussed in more detail in Chapter 3, the decision to use gatekeepers for recruitment from a vulnerable population, and allowing the gatekeepers to decide which people are informed about the study at all, is seen by some as a necessary layer of protection, but by others (more recently by survivors themselves) is viewed as another way of taking away agency from survivors. In the past, research has often relegated members of vulnerable populations (children, people with disabilities, abuse survivors, etc.) to passive roles, and has directly or indirectly questioned their ability to make decisions that are right for themselves.

More recently however, members of these groups have voiced their objections and advocated for research methodologies such as Participatory Action Research (Baum et al., 2006) and Emancipatory Research (Oliver, 1997). Given how important having agency over one's body, mind, and life decisions is to those who were denied it throughout their abuse, researchers who are in a position to should engage directly with the intended beneficiaries of their research at as many levels of the research process as possible. Some elements of participatory research were utilised in this study, such as gathering input on the interview schedules from a survivor, interviewing stakeholders, and giving survivors a chance to reflect back on their interview transcripts, but further efforts could have been taken to involve survivors and clinicians at other stages of the study.

4.4.3.2 Lack of Male and Non-Binary, and Openly LGBTQ+ Participants. There was an expected limitation around the lack of gender and sexuality diversity in the study. As concluded in Chapter 2, cisgender male and non-binary participation in research about sexual abuse is generally quite low compared to that of cisgender women. This may be due to fewer researchers setting out to study CSA in male and gender non-binary survivors, as well as these groups being more reluctant to participate in this research for various reasons (some of which are detailed in Chapters 2 and 3, and above). LGBTQ+ participants were also not involved in the study, at least explicitly—the sexualities of the survivors was not asked or a point of discussion, so it is not possible to be completely certain that they did not identify as LGBTQ+. This is partly because the study did not aim to specifically recruit LGBTQ+ survivors (whereas much social science research with these populations targets them explicitly). However, perhaps this kind of specificity is needed in recruitment materials to encourage certain populations (including men) to participate, as they may not see themselves as the default target population for research studies otherwise.

4.4.3.3 Influence of Long-Term Therapeutic Journey on Survivor Narratives. Lastly, while not a barrier in terms of the amount or quality of data the study was able to collect, the influence of both survivors' long-term experiences in therapy can be clearly seen in their narratives. As they have had the time and guidance to unpack their shame and general abuse experience, and have to some extent internalised self-confidence and resilience, their narratives reflect this intellectual understanding—they are both able to easily articulate the 'whys' and 'hows' of many of their feelings and actions, for one thing. For example, both are able to identify how their shame manifests in their lives today, and when and why their shame, guilt, etc. started to develop.

It is clear that they have spoken at length about their abuse and emotions many times before. This could be a reason that so many of the themes in the survivor interviews are also triangulated by the clinician interviews—as the survivors are clients of the same clinic, it makes sense that the way they frame certain events relating to their abuse is influenced by how their therapists frame and discuss those events. What is missing from this study then (among other

things mentioned above), are the voices of survivors at other stages of their therapeutic journeys. A longitudinal analysis of narratives could then provide richer data on the linguistic, affective, and sentiment changes in how survivors tell their stories at the start, middle, and end of their engagement with therapy.

Chapter 5: Concluding Remarks

5.1 Recap of Project Aims and Novelty of Research

The overarching aim of this PhD project was to explore the experience of shame in adult survivors of child sexual abuse in Ireland using a mixed-methods approach. In order to achieve this aim, three empirical studies were conducted: 1) a large-scale systematic review and narrative synthesis of existing research (both qualitative and quantitative) on shame in the context of CSA, 2) a quantitative evaluation of a trauma-related shame scale and related outcomes in a population of CSA survivors, and, 3) in-depth interviews with CSA survivors and service providers working within the field of CSA and FGM. This project marks the first set of studies (to my knowledge) to specifically focus on the outcome of CSA-related shame within the Irish context, and with adult survivors, with service providers' perspectives taken into account.

Taken together, these three studies' findings tell a story of the ways in which the world around the survivor—its systemic and socio-cultural factors—work to compound the shame initially implanted in them by their abuser. They reveal that CSA shame may be unique in its integral, entrenched nature within survivors, due to the early developmental disruptions of the survivors' sense of self and the difficulty of releasing this shame through the survivors' lifetimes, in large part because of repeated socio-cultural reinforcement of the shame.

The urgency of addressing these factors first and foremost has been laid bare, particularly in the first-hand accounts of the survivors interviewed for this project. While improvements in clinical tools to help mitigate shame are needed eventually, the more pressing need for survivors is an environment conducive to early disclosure and transformation of shame into more 'productive' emotions, such as self-compassion. Only through radical systemic and cultural changes will meaningful progress in preventing shame be achieved.

5.2 Recap of Empirical Research Findings

5.2.1 Systematic Review

The first phase of this project, the systematic review and narrative synthesis, analysed 168 studies dealing in some way with shame in the context of CSA. Eighty-one of these studies were quantitative, 81 were qualitative, and six were mixed-methods. The vast majority of these studies were conducted in WEIRD (western, educated, industrialised, rich, and democratic) populations, indicating a potential bias in the research findings and an inability to generalise the results to the global majority. Furthermore, most research involved women survivors, revealing an inadequate evidence base on male survivors' experiences of shame.

One implication of having this body of research dominated by WEIRD samples, is that our understanding of barriers and facilitators to CSA disclosure and the development of shame, and the consequent theory-related developments in the field, are likely to be based on particularities of a very unique population. The vast majority of the world's population does not exist within the types of economic and political structures of WEIRD samples. This major discrepancy thus affects every aspect of a survivor's post-abuse experience, from whether they can capture the attention/care of authorities like the police in the first place, to whether they can receive adequate medical and mental health care. For instance, while the issue of family honour/reputation (discussed in Chapter 2 in relation to non-WEIRD studies) is a barrier to disclosure in both WEIRD (as evidenced by Chapter 4's survivor interviews) and non-WEIRD samples, there is at least some difference in the extent to which this affects how survivors are treated—the level of legitimacy that formal avenues of justice have in a community (e.g. perhaps less legitimacy in places with high levels of political corruption) may be an important factor in determining how influential community beliefs regarding family honour ultimately are. So while some underlying dynamics (i.e. family honour being of concern to community members) may be similar across several cultures, the socioeconomic structures overlaid on them are likely to moderate their effect on survivors.

The synthesis of findings from the studies in this review revealed several major themes. Firstly, shame is an extremely common (arguably inevitable) consequence of CSA—only two studies

showed evidence of some survivors seemingly not experiencing this. Related to this, the quantitative evidence base also demonstrates clear links between CSA shame and a range of poor mental health, social, and somatic problems. Self-compassion was identified as a potential mitigating factor for shame, though existing evidence is not strong enough to come to a consensus on its effectiveness (and therefore this should be a target for future research).

Another major aspect of shame in the CSA context is the intensely negative effect it has on survivors' desire and ability to disclose their abuse; signals survivors receive from family, community, and the general public about prevailing attitudes towards survivors discourage many from coming forward and seeking help. This is extremely detrimental to survivors' recovery processes, as research has also shown that the act of disclosure itself is a way of resisting and releasing shame.

Finally, the review found that there was a lack of appropriate tools for measuring shame in CSA survivors. While there exist several overall shame and trauma-related shame scales, they are not specific to CSA-related shame, which, through the current project and previous research, has been established to involve unique facets that are not addressed by a general model of trauma-related shame. Therefore further research is required to establish what exact factors existing scales are not tapping into, and to design novel shame measurement tools (that ideally combine self-report, clinician-administered, and behavioural assessment methodologies) for this population. Future studies looking into developing this sort of tool may want to look to the FACS (discussed in Chapter 2) or similar methods as examples of behavioural assessments, as they may be particularly suited for use in this population—as discussed in Chapters 2 and 4, many survivors don't express shame verbally (perhaps because they may not have identified it in themselves yet, for example), but rather do so via body language (such as chronic avoidance of eye-contact, shrinking into themselves, etc.). Triangulating self-report and clinician measures of shame with a behavioural assessment therefore would offer more insight into how far along a survivor is in their journey of healing from shame. However, issues of the validity of such measures need to be taken

into account as well; cross-cultural validity studies of measures of facial emotions would need to be conducted extensively, as many emotions are expressed differently across cultures (Chen and Jack, 2017; Chen et al., 2018; Rojahn et al., 2000).

5.2.2 Quantitative Evaluation of Trauma-Related Shame in the Context of CSA

Following on from the findings of the systematic review, an evaluation of an existing measure of trauma-related shame in the context of CSA shame was undertaken. The study used an anonymous online questionnaire to measure levels of general shame, CSA-related shame (measured using the Trauma-Related Shame Inventory as a proxy), PTSD, self-compassion, trauma-related guilt, and depression. CSA survivors from a psychotherapy clinic, and social media support groups for survivors, and a service supporting migrant women were recruited; 37 participants provided complete datasets on these variables. Correlations between the variables listed above were tested; the time participants had spent in therapy in adulthood was also added as a variable. Then, hypothesised models of relations between PTSD and CSA-related shame, and CSA-related shame and depression, were tested using linear multiple regressions, testing for the role of self-compassion as both a mediator and moderator in these relationships.

Bivariate correlations showed significant relationships between CSA-related shame and general shame, self-compassion, and depression, and PTSD. Time in therapy did not correlate significantly with any other variables tested. Self-compassion did not emerge as a mediator or moderator of the relationship between PTSD and CSA shame, nor did it emerge as a moderator in the relationship between CSA shame and depression. The lack of mediation/moderation may be a result of the regression models not being sufficiently powered to detect anything smaller than large effects. However, direct relationships between PTSD and CSA shame, and between self-compassion and depression, were found.

The results of this study provide some support to the findings of the systematic review; like most quantitative research on the topic, this study demonstrates significant relationships between shame and adverse mental health outcomes. The significant (negative) correlation

between shame and self-compassion is consistent with the hypothesis that suggests self-compassion is an appropriate mechanism by which shame in survivors might be mitigated. The lack of correlation between time in therapy and either self-compassion or shame levels suggests that there are some aspects of CSA-related shame and the kinds of therapeutic processes survivors undergo that remain to be understood properly.

5.2.3 Survivor and Service Provider Experiences and Perspectives on Shame in the Context of CSA

The final study of this project was a qualitative examination of CSA-related shame from the perspectives of survivors and service providers working in the field. Two white Irish women survivors were recruited from the same clinic we collaborated with for the quantitative study. Two therapists from this clinic were also recruited, as was one service provider from the service supporting migrant women mentioned above. In-depth semi-structured interviews based on biographical narrative interview methodology were carried out with these participants. Given the heterogeneity of the survivors' accounts, interpretative phenomenological analysis was used to examine their interviews, while general thematic analysis was used for the service provider interviews.

Results of the survivor interviews revealed a handful of major themes. Firstly, the essential nature of shame in the identities of the survivors, and the immense difficulty they continue to have in separating their identities from their abuse (i.e. 'I am my abuse') emerged. Secondly, both accounts paint a picture of the collective failure of the adults in these women's lives to protect them from further abuse, and to believe them when they attempted to disclose the abuse. Furthermore, they recount several experiences of people in positions of authority, such as teachers and doctors, shaming them as children for displaying behaviours resulting from their abuse and for 'throwing around' accusations of abuse. They also detail the social and medical difficulties they still face as a result of shaming (both explicit and inadvertent) by medical professionals and in their social circles.

The therapist interviews triangulated most of the themes that emerged in the survivor interviews while adding a couple of unique insights. Firstly, the therapists pointed out that, to them, the reduction of shame is apparent when clients start displaying more self-compassionate behaviours over time; self-compassion is also a core element of their (and the other therapists at the clinic's) practice, regardless of which specific modalities they otherwise specialise in. Differences in male and female clients' experiences of shame were also discussed, with one therapist observing that the gender of the perpetrator(s) seemed to really have an impact on survivor shame; specifically, the severity of abuse committed by female perpetrators tends to be downplayed by society, but the impact of female perpetrators is uniquely shaming, particularly for male victims. The need for more widespread training among psychological and medical professionals on the specificities of dealing with CSA was also identified.

Finally, the interview with the service provider from the service supporting migrant women also echoed much of what the survivors talked about. In addition, this interview provided insight into how women who have undergone FGM may experience shame in their home countries, and then when they arrive in Ireland—in particular, she made the vital point that in their countries of origin, women with FGM may have been in the majority, and therefore may not have experienced shame stemming from their FGM. However when they arrive in Ireland and are met with messaging that is negative towards FGM, some women may begin to feel ashamed of themselves, their bodies, and of being a part of their culture.

5.3 Socio-Cultural, Systemic, Research, and Clinical Implications in Shame Prevention and Mitigation

While at the beginning of the PhD, this project was oriented towards creating an evidence base for further evaluation of specific shame measurement tools in the effort to improve the experience of survivors in the clinical setting, the results of the project have made it clear that there is a more urgent need for research into what can be done to reduce socio-cultural factors that add to survivors' shame within the Irish context. While a psychometrically valid and reliable

measurement tool for CSA-related shame is certainly needed in due course, without preventative measures to reduce the chances of shame becoming ingrained in survivors' identities, the utility of such measures in therapy is greatly diminished. The disproportional weight that cultural reactions and attitudes towards survivors have when it comes to the incitement of shame, reflects a crucial aspect of shame that Stearns (2017) puts forth in his book; shame is not only a self-conscious emotion, but a socially-conscious one—without the enforcement of shame by social groups, it could not exist.

With that in mind, some suggestions for inciting socio-cultural and systemic change (some of which are likely being designed or piloted already) for better mental health outcomes for survivors are outlined below. As discussed in more detail in Chapter 4 though, a major roadblock to implementing these suggested interventions is adequate funding in the healthcare and education systems; the amount of political will to tackle long-term consequences of CSA is therefore a rate-limiting factor to account for.

5.3.1 Suggestions for Socio-Cultural and Systemic Interventions to Prevent the Development of Shame

One of the generational changes currently unfolding in Ireland stems from the impact of CSA within the Church, and the public revelation of this abuse in the reports described in Chapter 1. The societal deficits and the lifelong wounds brought to light by this scandal (and similar revelations of abuse in Church-run schools that are still coming out), as well as by the revelations of the extent of abuse in mother and baby homes, is slowly but surely leading to widespread cultural change around the treatment of (C)SA survivors and disclosure. For example, a study by Goode et al. conducted in 2003 was already showing meaningful changes in the public's condemnation of the Church for their handling of CSA cases and of the systemic factors that allowed much of the abuse to go unchecked. The impact of this aspect of cultural change was also seen in the results of the 2018 abortion referendum, which signalled the rejection of religious influence on the healthcare system.

Something that can aid this larger cultural shift in attitudes towards sex and sexual abuse, is public awareness campaigns focused on reactions to CSA. These campaigns can be highly impactful if widespread and tailored to a range of audiences—particularly with the ubiquity of social media. Recent examples of this are the Immigrant Council of Ireland’s anti-racism ad campaign (which was rolled out largely on public transportation), and a campaign by the Irish government to raise awareness about legislation on non-consensual sharing of intimate images/videos. Perhaps the best recent example is the ‘Assume That I Can’ campaign by Italian organisation CoorDown, which garnered global praise for its communication of how the infantilisation of adults with Down syndrome becomes a self-fulfilling prophecy; the ad already seems to be making many people reconsider their preconceptions of those with Down syndrome (Holohan, 2024). Within Ireland, services supporting migrant women are in the process of creating a social media campaign (including a story-based short film), to raise awareness of FGM, and to deter women from having FGM performed on their daughters. A similar approach, calling out the way people react and respond to disclosures of CSA and focusing on ways to react that are less likely to elicit shame, would be a huge first step.

On the systemic level, significant improvement to the child protection training offered to teachers is needed. While Ireland does implement the Stay Safe programme in primary schools to promote child safety and educator competence in awareness-raising and spotting signs of abuse, a recent evaluation by Nohilly (2019) found that many teachers thought the training and its enforcement left a lot to be desired. Again, a specific focus on the reactions of teachers to disclosures or suspicions, and awareness of how certain reactions may cause shame, is needed. There is also a need to train medical professionals on how to appropriately communicate and react to disclosures of CSA, both current and historical, as doctors, nurses, and midwives are often the first point of contact for survivors.

5.3.3 Suggestions for Clinical and Research Interventions to Mitigate Shame Based on what was found in this study, interventions in clinical practice relating to shame might include increased

training for clinicians in compassion-focused approaches (e.g., Beaumont et al., 2021), and in how to incorporate these approaches in other approaches such as trauma-focussed CBT, which is one of the more common modalities used in mental health care (Beaumont et al., 2016). Ideally, in-depth training on working with CSA survivors, with input from survivors themselves (such as having survivors create materials and conduct lectures) could be a requirement in any professional psychotherapy course. From what the survivors interviewed in Chapter 4 have said, it seems that many non-CSA specialised psychologists practising are still unsure of how to handle disclosures, immediately relegating CSA survivors to a higher level of severity (even though most CSA survivors will go to general psychologists for many years before seeking out someone who specialises in CSA).

As indicated by one of the survivors, providing signals to survivors that a clinic or clinician is capable of handling CSA disclosures and CSA-related mental health struggles via simple additions like a checkbox asking about current experiencing of shame on an intake form, may go a long way to reassure survivors of the safety of that particular setting. Related to this would be the development of a CSA-specific measure of shame, as discussed in Chapters 2 and 3, which requires rigorous research first to determine the factors of shame missing from existing shame constructs. Finally, the incorporation of FGM education for medical and mental health professionals seems to be needed in Ireland, as does the inclusion of FGM into the larger corpus of CSA research. While this project attempted to study the experiences of FGM survivors, ultimately this goal did not materialise; however, as discussed in Chapter 3, this project elucidates the various challenges in researching within this population in Ireland, and provides suggestions for enabling this research in the near future.

Lastly, on a methodological note, a crucial step researchers are encouraged to take in further research on shame in CSA survivors, is to adopt a more survivor-controlled research paradigm (discussed in Chapters 3 and 4)—looking back on this thesis, while there was some engagement with survivors and other stakeholders in the design stages of this study, a clear CBPR

or PPI approach, adopted at perhaps even the grant-writing stages of the project, would have allowed for a sense of equitable and open contribution to the studies, which may have potentially even increased sample sizes as well as the legitimacy of the research findings among the CSA survivor population. A major factor to consider in taking up this approach is accounting for the extra funding that CBPR/PPI panels, and methodological training, would require. However, as these approaches head towards being more standardised in the field, funders are more likely to view the suggestion of such a paradigm as an asset.

It is our hope that the breadth of findings from this thesis, the resilience of the individuals who generously contributed their stories, and the long-term picture of hope illustrated by the service providers inspires other researchers to take on this difficult topic, and further the research started here.

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Appendix A: Systematic Review Data Extraction Tables Link

<https://docs.google.com/spreadsheets/d/1UP8ulmDcAD75QL6Yk47TZDxnBug4ywfutGiSzi6dth4/edit?usp=sharing>

Appendix B: Systematic Review Preregistration Link on Prospero

[https://www.crd.york.ac.uk/prospero/display_record.php?RecordID=134818.](https://www.crd.york.ac.uk/prospero/display_record.php?RecordID=134818)

Appendix C: Quantitative Study Overall Ethics Approval



Coláiste na Tríonóide, Baile Átha Cliath
Trinity College Dublin

Ollscoil Átha Cliath | The University of Dublin

Shaakya Vembar
School of Psychology
Aras an Phiarsaigh
Trinity College Dublin
Dublin 2
Ireland

28th June 2021

Ref: 210403

Title of Study: Exploring Shame in Adult Survivors of Child Sexual Abuse

Dear Shaakya,

Further to a meeting of the Faculty of Health Sciences Ethics Committee held in April 2021. We are pleased to inform you that the above project has ethical approval to proceed.

This study has been ethically approved. We would advise you to seek review and comments on your DPIA from the DPO if required prior to study commencement'

As a researcher you must ensure that you comply with other relevant regulations, including DATA PROTECTION and HEALTH AND SAFETY.

Yours sincerely,

A handwritten signature in dark ink, reading 'Jacintha O'Sullivan'.

Prof. Jacintha O'Sullivan
Chairperson
Faculty Research Ethics Committee



Coláiste na Tríonóide, Baile Átha Cliath
Trinity College Dublin
Ollscoil Átha Cliath | The University of Dublin

Shaakya Vembar,
School of Psychology Aras an Phiarsaigh,
Trinity College Dublin, Dublin 2, Ireland

27th January 2023

Ref: 210403

Title of Study: Exploring Shame in Adult Survivors of Child Sexual Abuse (Survey)

Dear Shaakya,

Further to a meeting of the Faculty of Health Sciences Ethics Committee held in January 2023, we are pleased to inform you that the above project (as amended with the following changes) has ethical approval to proceed.

Please give specific details of the requested amendment(s):

Extension until September 2023.

Request for approval of alternative recruitment procedure

Our original study, approved by this research ethics committee, aimed to recruit adult survivors of child sexual abuse through [REDACTED]. Participants were invited to complete online questionnaires about shame and child sexual abuse. All participants invited to take part in the study were currently receiving psychological therapy [REDACTED].

We have not been able to recruit sufficient participants through this site to achieve suitable power for our statistical analyses and are hence looking to recruit from another site.

This amendment requests approval to advertise our study and recruit adult survivors of child sexual abuse through private Facebook support groups for adult survivors of child sexual abuse. Such participants would complete the same questionnaires as originally approved, with some minor changes listed in detail below. The researchers (Shaakya, Simon, and Elizabeth) will NOT be joining these groups, but rather liaising with a gatekeeper to share the survey link.

We have designed this element of the study in conjunction with a survivor of child sexual abuse [REDACTED]. The specific Facebook support groups we will advertise in are ones in which [REDACTED] is an active member or moderator (please see attached Letter of Support [REDACTED]). These groups are:

i. [REDACTED]
[REDACTED]
[REDACTED]

Below is the text that we are proposing for the actual posts [REDACTED] will share in the support groups. We will include the participant information leaflet in the post (so that participants don't have to click into the survey itself to get information about the study), either as a file attachment or as a Google Docs link. We have also emphasized in the PIL, text in the post, and the consent form that participants should take their time to think about the survey, and that there is no need for them to complete the survey immediately, or at all.

Proposed text for Facebook group posts:

"Researchers at Trinity College Dublin are inviting adult survivors of child sexual abuse, and who are currently undertaking psychological therapy (are engaging with therapists or counsellors), to participate in an ANONYMOUS online questionnaire about shame and child sexual abuse. If you'd like to find out more about this study and consider participating, please have a look at the Participant Information Leaflet attached to this post. If and when you would like to participate (it does not need to be right now, today, or this week, you can take your time to think about it), please click here [insert link]"

An important part of the design of our original study was that participants were already undertaking psychological therapy. This meant that participants already had a support network in place, in case any of the questions on the survey caused distress. To ensure that participants recruited via these Facebook groups also have support in place (in addition to the sources of support we already list in our Participant Information Leaflet), we have changed our inclusion criteria to include that the person is currently undertaking psychological therapy.

We have discussed the research and this study with [REDACTED] in detail, and she has made suggestions for changes in the survey's consent form and the instructions to one of the scales in the survey, in order to adapt both to the potential participants in the support groups. We are happy to take on these suggestions as they do not alter the survey in any significant way; the changes are detailed in the attached consent form, participant information leaflet, and survey draft, highlighted in blue.

Please also see the link to the online survey itself:

[REDACTED]

Here is a summary of the changes we are incorporating based on [REDACTED] advice:

Consent form and participant information leaflet changes:

- As participants are no longer being invited [REDACTED] to take part in the study, but are instead being approached directly through Facebook, we have included details at the start of the consent form explaining who we are inviting to take part in the study.
- Amending the language in the 'What does participation involve' section
- Adding additional information in the 'potential risks' section
- Adding a link to a primer on GDPR for research to the 'Anonymity, Data Protection, and Data Usage' section
- Adding additional sources of help to the header (which appears on each page of the survey online)
- Expanding explicit consent checklist

Survey body changes:

- Demographic questions
 - Slight change of wording in Q2 about gender
 - Change in options and wording of Q3 about time in therapy
 - Addition of an option in Q4

- Psychological scales
 - Addition of a minor instruction before introduction of scales
 - Addition of a minor instruction in the instructions for the Test of Self-Conscious Affect-3 scale

As a researcher you must ensure that you comply with other relevant regulations, including
DATA PROTECTION and HEALTH AND SAFETY.

Yours sincerely,



Prof. Jacintha O'Sullivan
 Chairperson Faculty Research Ethics Committee

Appendix E: Quantitative Study Migrant Women's Service Ethical Approval Letter



Coláiste na Tríonóide, Baile Átha Cliath
Trinity College Dublin
Ollscoil Átha Cliath | The University of Dublin

Shaakya Vembar,
School of Psychology,
Aras an Phiarsaigh,
Trinity College Dublin,
Dublin 2,
Ireland

7th July 2023

Ref: 210403
Title of Study: Exploring Shame in Adult Survivors of Child Sexual Abuse (Survey)

Dear Shaakya,

Further to a meeting of the Faculty of Health Sciences Ethics Committee held in July 2023, we are pleased to inform you that the above project (as amended with the following changes) has ethical approval to proceed. Your approval is pending subject to approval of your local DPO.

Please give specific details of the requested amendment(s):

Amendment to add Recruitment [REDACTED]

As a researcher you must ensure that you comply with other relevant regulations, including DATA PROTECTION and HEALTH AND SAFETY.

Yours sincerely,

Prof. Jacintha O'Sullivan
Chairperson Faculty Research Ethics Committee

Dámh na nEolaíochtaí Sláinte
Foirgneamh na Ceimice,
Colaiste na Tríonóide,
Ollscoil Átha Cliath,
Baile Átha Cliath 2, Éire.

Faculty of Health Sciences
Chemistry Building,
Trinity College Dublin,
The University of Dublin,
Dublin 2, Ireland.

www.healthsciences.tcd.ie

Appendix F: Quantitative Study Consent Form Example

Appears as the first page of the survey

Dear respondent,

The following questionnaire is part of a larger research project on shame in adult survivors of child sexual abuse. The study is being conducted by Shaakya Anand-Vembar, a PhD student at Trinity College Dublin, under the supervision of Dr. Simon McCarthy-Jones and Dr. Elizabeth Nixon, and in partnership with [redacted].

Aims

The aim of the larger study is to create a clinical measure of shame tailored to survivors of child sexual abuse, in order to better address survivors' needs in a clinical setting. We hope to use the results of this questionnaire to understand shame and what it means for survivors.

What does participation involve?

The questionnaire consists of some questions about information such as age and gender, and six scales measuring a range of psychological concepts like mood, state of mind, and how you feel about yourself. You will not be asked to provide any personally identifiable data. The questionnaire will take around 20 minutes to complete. **Please keep in mind that some of these scales require you to think back to your child sexual abuse experience(s) and how you felt afterwards.**

Potential Risks

As some of the scales ask you to respond to them in the context of your abuse experience(s), there is a risk of experiencing mental distress due to recalling your child sexual abuse experience(s).

If you feel like you would experience a high level of distress, please do not participate in the study. If you decide to participate, we strongly encourage you to fill out the questionnaire during standard business hours (between 9am-5pm). This means that you can contact somebody from [redacted] or another organisation in the event that you are distressed afterwards. There are no other foreseeable risks to taking part in this study.

You may quit the study at any time while completing the questionnaire by exiting the window, but you will not be able to withdraw your data after submitting the survey responses, as we won't know which responses are yours. Finally, counseling services will be indicated at the top of each page of this questionnaire if you feel the need to contact any during the process.

Anonymity, Data Protection, and Data Usage

Your safety and anonymity is of the utmost importance to us, and we have taken steps to ensure your identity is protected through every step of the study.

This questionnaire complies with data protection law and has received ethical approval from Trinity College's School of Medicine. **Your responses will remain completely anonymous. We are NOT collecting any identifying information (such as your name, phone number, email, home address, IP address, job, etc.).**

Data will be stored initially on the secure, cloud-based Qualtrics server, and will only be accessible by the data processors (indicated below). After this, the data will be transferred to a secure, cloud-based drive accessible only by the data processors, as well as to a password-protected harddrive that will be stored under lock and key. Data will be analysed at the group level. We plan on using the information collected

via this study in scientific publications such as journal articles, poster presentations, and infographics or educational leaflets, as well as for developing future stages of the Shame and Child Sexual Abuse project.

Researcher contact information:

Shaakya Anand-Vembar, PhD Student (Data processor)
Department of Psychiatry Trinity College Dublin vembars@tcd.ie

Dr. Simon McCarthy-Jones (Data processor)
Associate Professor in Clinical Psychology and Neuropsychology Department of Psychiatry
Trinity College Dublin simon.mccarthy-jones@tcd.ie

Dr. Elizabeth Nixon (Data processor)
Assistant Professor in Developmental Psychology School of Psychology
Trinity College Dublin enixon@tcd.ie

If you would like to continue with this study, please indicate your informed consent in the question below. If you don't wish to participate, please exit this window now; we thank you for your time.

Have you read and understood the information presented above, and do you consent to participating in this study?

- Yes, I consent to participating in this study.
- No, I do not consent to participating in this study (the survey will end at this point if you choose this option).

Appendix G: Quantitative Study Participant Information Leaflet Example



Trinity College Dublin
Coláiste na Tríonóide, Baile Átha Cliath
The University of Dublin

Participant Information Leaflet

This is an information sheet about a Trinity College Research study, being conducted by professors and students in the School of Medicine.

The purpose of this information sheet is to provide an overview of the study and our obligations regarding data protection, so that potential participants can decide whether or not to participate in the study. **If you have any queries or require any further information, please get in touch with Shaakya Vembar at vembars@tcd.ie**

Name of Study: EXPLORING SHAME IN ADULT SURVIVORS OF CHILD SEXUAL ABUSE (QUESTIONNAIRE)

Site	Online, via [redacted]
Principal Investigator(s) and Co-Investigator(s) (insert names, titles and contact details)	1. Shaakya Vembar (PhD Student, Department of Psychiatry, Trinity College Dublin); vembars@tcd.ie 2. Dr. Simon McCarthy-Jones (Trinity Centre for Health Sciences, St. James' Hospital); simon.mccarthy-jones@tcd.ie 3. Dr. Elizabeth Nixon (School of Psychology, Trinity College Dublin); enixon@tcd.ie
Study Organiser/ Sponsor (if applicable)	[redacted]
Data Controllers	Trinity College Dublin
Data Protection Officer	Data Protection Officer Secretary's Office Trinity College Dublin Dublin 2

You are being invited to take part in a completely anonymous online research study that is being done by Shaakya Vembar, a PhD candidate at Trinity College Dublin, in partnership with [redacted].

Before you decide whether or not you wish to take part, please read this information sheet carefully. Ask Shaakya any questions by emailing her at vembars@tcd.ie. Don't feel rushed or under pressure to make a quick decision—you do not have to participate in this study at all. You

should understand the risks and benefits of taking part in this study so that you can make a decision that is right for you. You may wish to discuss it with your family, friends, or a clinician.

This leaflet has five main parts:

- Part 1 – The Study
- Part 2 – Data Protection
- Part 3 – Costs, Funding and Approval
- Part 4 – Future Research
- Part 5 – Further Information

Part 1 – The Study

Who are we?

We are a PhD student in the Department of Psychiatry at Trinity College, and two professors in the Department of Psychiatry (Dr. Simon McCarthy-Jones) and the School of Psychology (Dr. Elizabeth Nixon) at Trinity College. We are collaborating with [redacted], which you have engaged with before.

What is this study about?

We want to explore the feeling of shame in adult survivors of child sexual abuse to better address survivors' needs in a clinical setting. We hope to use the results of this questionnaire to understand shame and what it means for survivors.

Why have I been asked to take part?

You have been invited to take the questionnaire as you have a history of child sexual abuse and are an adult, you have engaged with or are a current client of [redacted], and you are currently engaged in some form of counselling/therapy.

Do I have to take part?

You do not have to take part. Taking the questionnaire is completely voluntary, and you will not face any negative consequences for not participating. You can also stop completing the questionnaire at any point without any negative consequences.

While filling out the questionnaire, you may take breaks and return to the questionnaire. You may also want to stop responding part-way and come back to the questionnaire the next day—this can also be done as long as you don't close the window/tab on your computer that has loaded the questionnaire.

However, as your data will be completely anonymous, you will not be able to withdraw your data from the questionnaire once you have started responding, because we will not be able to link your identity to your responses.

What does taking part involve?

If you decide to take part, you will click on the link to an anonymous online questionnaire (which has been provided you with via email or in a WhatsApp message). There are questions on age, sex, and gender, as well as six scales which measure things like mood, and feelings. All of the questions will be multiple-choice, so you won't have to give any written responses. Please keep in mind that some of these scales require you to think back to your child sexual abuse

experience(s) and how you felt afterwards. **You will not be asked to provide any personally identifiable data (like your name, email, etc.)**

The questionnaire will take around 20 minutes to complete. You do not have to fill out the questionnaire immediately after seeing this email or WhatsApp message; you may take as much time as you need to think about whether you want to participate.

The following are the scales that you will see in the questionnaire:

1. Test of Self-Conscious Affect (Shame Items)
 - . These questions ask how you would react to some everyday scenarios
2. Trauma-Related Shame Inventory
 - . These questions measure how much different types of reactions to trauma apply to you (you will be asked to think of your CSA experience(s) for this)
2. Self-Compassion Scale
 - . These questions ask how you typically act towards yourself in difficult times
2. Impact of Events Scale
 - . These questions ask how distressing various difficulties are for you (you will be asked to think of your CSA experience(s) for this).
2. Beck Depression Inventory
 - . These questions ask how your general mood has been over the past two weeks.

Can I change my mind?

You do not have to complete the questionnaire, even after you start giving responses. You will not face any negative consequences for exiting the questionnaire. **However, we will not be able to delete your data if you decide to quit the study after you begin responding to the questionnaire, as we will not know which responses are yours.**

What will happen to the information?

The anonymous information you give us will be used as part of a PhD project, which means it will be analysed and used in journal articles and presentations. Your data will be stored on a password-protected computer to which only the investigators named above will have access. Eventually the data (which will always remain anonymous,) might be shared on a public scientific database so that other researchers around the world can also make use of it. If we choose to do this, data such as age and gender will not be included.

What are the risks associated with participating?

As some of the scales ask you to respond to them in the context of your abuse experience(s), there is a risk of experiencing emotional distress due to recalling your child sexual abuse experience(s). You may also experience dissociation, flashbacks, or anxiety in the weeks after taking part in the study. If this is the case, please contact one of the service providers highlighted at the top of each page of the survey, or your therapist/counsellor if you have one.

When considering if you'd like to participate in this study, we strongly urge you to gauge the level of distress you think you would experience answering questions related to your abuse. **If you feel like you would experience a high level of distress, please do not participate in the study.**

We also discourage participation if you are not currently engaged with a counselling service.

If you decide to participate, we strongly encourage you to fill out the questionnaire in a private location where you feel relaxed and comfortable. If you prefer, you may complete the questionnaire with a friend, partner, or counsellor in the room with you.

Additionally, a list of support services and their contact information will be included on each page of the questionnaire in case you need support afterwards.

Here are the support services you may wish to contact in case of distress:

- . **One in Four (9am-5pm): 01 662 24070**
- . **Samaritans Ireland (24 hours): 116 123**
- . **National Rape Crisis Helpline (24 hours): 1800 77 8888**
- . **Women's Aid Ireland (24 hours): 1800 341 900**
- . **Men's Aid Ireland (9am-5pm): 01 554 3811**
- . **Spirasi (9am-5pm): 01 838 9664**

Samaritans Ireland: 116 123

- . **LGBT Ireland (Monday – Thursday (6.30pm – 10pm), Friday (4pm-10pm), Saturday and Sunday (4pm-6pm) : 1890 929 539**

- . **Connect Counselling Service, HSE (6pm-10pm): 1800 477 477**

Will I get feedback about the study?

As the questionnaire is completely anonymous and we won't know which responses are yours, we will not be able to provide individual feedback about the study. However, you are free to email the lead researchers stated above if you are curious about updates in the future.

Why is this study important?

Shame is a very common consequence of child sexual abuse and can last for many years or decades after the abuse. We know that abuse-related shame is linked to other negative effects, such as post-traumatic stress disorder, and negative physical effects. However, there isn't a lot of research into shame when it comes to child sexual abuse, so this study aims to add to that field. It is really important that we learn how to prevent and reduce shame in survivors so that other long-term negative consequences can be avoided too.

How will this research benefit me?

You may not benefit directly from taking part in this research project. But your responses will greatly help psychologists and others working with survivors of child sexual abuse to understand how shame may affect survivors. Also, your responses will be the basis of future research into child sexual abuse-related shame, which may result in a questionnaire that can be used to measure how much shame a person is feeling in relation to their abuse.

Part 2 – Data Protection

What information about me (personal data) will be used as part of this study?

We will not collect any personal or identifiable information (e.g. your name, email, address, place of work, etc.,) **even in the consent form.** So all of your information provided in the questionnaire will be anonymous. We will retain all consent forms for seven years after the end of the study (December 31st, 2030), as we are legally required to.

Part 3 – Costs, Funding, and Approval

Has this study been approved by a research ethics committee?

This study has been approved by the Faculty of Health Sciences Research Ethics Committee at Trinity College Dublin. Approval was granted on [June 28th, 2021].

Who is organising and funding this study?

The study is funded by Trinity College Dublin.

Will I be paid for taking part? Will it cost anything to take part?

There is no payment for participation in this study, nor are there any costs.

Part 4 - Future Research

Will the data be used in future studies?

We will keep the anonymised data for two years after the end of the study (December 31st 2025), or for as long as we need to, depending upon the reports/papers we write. We might also share **fully anonymised data** with researchers at other institutions (including outside the EU).

Part 5 - Further Information

Who should I contact for information or complaints?

If you have any concerns or questions, you can contact:

- *Principal Investigator: Shaakya Vembar, Department of Psychiatry, Trinity College, Dublin 2. Email: vembars@tcd.ie*
- *Data Protection Officer, Trinity College Dublin: Data Protection Officer, Secretary's Office, Trinity College Dublin, Dublin 2, Ireland. Email: dataprotection@tcd.ie. Website: www.tcd.ie/privacy.*

What should I do now?

At this point you can take as much time as you need to think about whether you want to participate in the study. If you want to participate, you can choose to take the questionnaire via the link provided in the email/WhatsApp message, and at your convenience. Alternatively, if you do not want to participate, you can simply ignore the link and the Facebook post.

Appendix H: Quantitative Survey Draft

(All responses are optional; participants won't be forced to answer any questions).

Part 2: Demographic questions

1. Did you complete this survey on your own or with your clinician?
 - On my own
 - With my clinician

1. Please indicate your age (in years): ____

0. Please indicate your gender:
 - Man
 - Woman
 - Other (please specify): _____

0. Please indicate for approximately how long you have been engaged with [redacted] (in months): ____

0. Was/were the perpetrator(s) of your abuse...
 - Someone within your household
 - Someone outside within your wider family
 - Someone outside your family

Part 3: Test of Self-Conscious Affect-3, Shame Items (Tangney, 2003)

Below are situations that people are likely to encounter in day-to-day life, followed by a common reaction to those situations. As you read each scenario, try to imagine yourself in that situation. Then indicate how likely you would be to react in the way described.

1. You make plans to meet a friend for lunch. At 5 o'clock, you realize you stood your friend up.

- You would think: “I’m inconsiderate.” 1 (not likely)-2-3-4-5 (very likely)

- 0. You break something at work and then hide it.
 - You would think about quitting. 1 (not likely)-2-3-4-5 (very likely)

- 0. 3. You are out with friends one evening, and you’re feeling especially witty and attractive. Your best friend’s spouse seems to particularly enjoy your company.
 - You would probably avoid eye contact for a long time. 1 (not likely)-2-3-4-5 (very likely)

- 0. At work, you wait until the last minute to plan a project, and it turns out badly.
 - You would feel incompetent. 1 (not likely)-2-3-4-5 (very likely)

- 0. You make a mistake at work and find out a coworker is blamed for the error.
 - You would keep quiet and avoid the coworker. 1 (not likely)-2-3-4-5 (very likely)

- 0. 6. For several days you put off making a difficult phone call. At the last minute you make the call and are able to manipulate the conversation so that all goes well.
 - You would think: “I did a good job.” 1 (not likely)-2-3-4-5 (very likely)

- 0. While playing around, you throw a ball and it hits your friend in the face.
 - You would feel inadequate that you can’t even throw a ball. 1 (not likely)-2-3-4-5 (very likely)

- 0. You have recently moved away from your family, and everyone has been very helpful. A few times you needed to borrow money, but you paid it back as soon as you could.
 - You would feel immature. 1 (not likely)-2-3-4-5 (very likely)

- 0. You are driving down the road, and you hit a small animal.
 - You would think: “I’m terrible.” 1 (not likely)-2-3-4-5 (very likely)

- 0. You walk out of an exam thinking you did extremely well. Then you find out you did poorly.
 - You would feel stupid. 1 (not likely)-2-3-4-5 (very likely)

0. You and a group of coworkers worked very hard on a project. Your boss singles you out for a bonus because the project was such a success.
- You would feel alone and apart from your colleagues. 1 (not likely)-2-3-4-5 (very likely)
0. While out with a group of friends, you make fun of a friend who's not there.
- You would feel small...like a rat. 1 (not likely)-2-3-4-5 (very likely)
0. You make a big mistake on an important project at work. People were depending on you, and your boss criticizes you.
- You would feel like you wanted to hide. 1 (not likely)-2-3-4-5 (very likely)
0. You volunteer to help with the local Special Olympics for handicapped children. It turns out to be frustrating and time-consuming work. You think seriously about quitting, but then you see how happy the kids are.
- You would feel selfish, and you'd think you are basically lazy. 1 (not likely)-2-3-4-5 (very likely)
0. You are taking care of your friend's dog while your friend is on vacation, and the dog runs away.
- You would think: "I am irresponsible and incompetent." 1 (not likely)-2-3-4-5 (very likely)
0. You attend your coworker's housewarming party and you spill red wine on a new cream-colored carpet, but you think no one notices.
- You would wish you were anywhere but at the party. 1 (not likely)-2-3-4-5 (very likely)

Part 4: Trauma-Related Shame Inventory (Oktedalen, 2014)

In this section of the survey, please respond to the following scale about trauma-related shame. As mentioned before, if you find that the survey is distressing you in any way, you are free to opt at any point.

Individuals who experience traumas often have many different types of reactions. Below are a number of statements that describe thoughts and feelings that people sometimes have about themselves. Please read each statement carefully, and decide how much it applies to you check the option that best describes how much the statement is true for you over the past week:

		Not true of me	Somewhat true of me	Mostly true of me	Completely true of me
(I)	As a result of my traumatic experience, I have lost respect for myself	☐	☐	☐	☐
(E)	Because of what happened to me, others find me less desirable	☐	☐	☐	☐
(I)	I am ashamed of myself because of what happened to me	☐	☐	☐	☐
(E)	As a result of my traumatic experience, others have seen parts of me that they want nothing to do with	☐	☐	☐	☐
(I)	As a result of my traumatic experience, I cannot accept myself	☐	☐	☐	☐
(E)	If others knew what happened to me, they would view me as inferior	☐	☐	☐	☐
(E)	If others knew what happened to me, they would be disgusted with me	☐	☐	☐	☐
(I)	I am ashamed of the way I behaved during my traumatic experience	☐	☐	☐	☐
(I)	I am so ashamed of what happened to me that I sometimes want to escape from myself	☐	☐	☐	☐
(I)	As a result of my traumatic experience, I find myself less desirable	☐	☐	☐	☐
(I)	I am ashamed of the way I felt during my traumatic experience.	☐	☐	☐	☐
(E)	If others knew what had happened to me, they would look down on me	☐	☐	☐	☐
(I)	As a result of my traumatic experience, there are parts of me that I want to get rid of	☐	☐	☐	☐
(E)	If others knew what happened to me, they would not like me	☐	☐	☐	☐
(I)	Because of my traumatic experience, I feel inferior to others	☐	☐	☐	☐
(E)	If others knew what happened to me, they would be ashamed of me	☐	☐	☐	☐
(E)	If others knew what happened to me, they would find me unacceptable	☐	☐	☐	☐
(E)	As a result of my traumatic experience, a part of me has been exposed that others find shameful	☐	☐	☐	☐
(E)	If others knew how I behaved during my traumatic experience, they would be ashamed of me	☐	☐	☐	☐
(I)	My traumatic experience has revealed a part of me that I am ashamed of	☐	☐	☐	☐
(I)	As a result of my traumatic experience, I don't like myself	☐	☐	☐	☐
(E)	If others knew how I felt during my traumatic experience, they would be ashamed of me	☐	☐	☐	☐
(I)	Because of what happened to me, I am disgusted with myself	☐	☐	☐	☐
(E)	I am so ashamed of what happened to me that I sometimes want to become invisible to others	☐	☐	☐	☐

Part 5: Self-Compassion Scale (Neff, 2003)

HOW I TYPICALLY ACT TOWARDS MYSELF IN DIFFICULT TIMES

Please read each statement carefully before answering. To the left of each item, indicate how often you behave in the stated manner, using the following scale:

- | | | | | | |
|-------------------------|----------|----------|----------|----------|--------------------------|
| Almost
never | | | | | Almost
always |
| 1 | 2 | 3 | 4 | 5 | |
-
- _____ 1. I'm disapproving and judgmental about my own flaws and inadequacies.
 - _____ 2. When I'm feeling down I tend to obsess and fixate on everything that's wrong.
 - _____ 3. When things are going badly for me, I see the difficulties as part of life that everyone goes through.
 - _____ 4. When I think about my inadequacies, it tends to make me feel more separate and cut off from the rest of the world.
 - _____ 5. I try to be loving towards myself when I'm feeling emotional pain.
 - _____ 6. When I fail at something important to me I become consumed by feelings of inadequacy.
 - _____ 7. When I'm down and out, I remind myself that there are lots of other people in the world feeling like I am.
 - _____ 8. When times are really difficult, I tend to be tough on myself.
 - _____ 9. When something upsets me I try to keep my emotions in balance.
 - _____ 10. When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people.
 - _____ 11. I'm intolerant and impatient towards those aspects of my personality I don't like.
 - _____ 12. When I'm going through a very hard time, I give myself the caring and tenderness I need.
 - _____ 13. When I'm feeling down, I tend to feel like most other people are probably happier than I am.
 - _____ 14. When something painful happens I try to take a balanced view of the situation.
 - _____ 15. I try to see my failings as part of the human condition.
 - _____ 16. When I see aspects of myself that I don't like, I get down on myself.
 - _____ 17. When I fail at something important to me I try to keep things in perspective.

- _____ 18. When I'm really struggling, I tend to feel like other people must be having an easier time of it.
- _____ 19. I'm kind to myself when I'm experiencing suffering.
- _____ 20. When something upsets me I get carried away with my feelings.
- _____ 21. I can be a bit cold-hearted towards myself when I'm experiencing suffering.
- _____ 22. When I'm feeling down I try to approach my feelings with curiosity and openness.
- _____ 23. I'm tolerant of my own flaws and inadequacies.
- _____ 24. When something painful happens I tend to blow the incident out of proportion.
- _____ 25. When I fail at something that's important to me, I tend to feel alone in my failure.
- _____ 26. I try to be understanding and patient towards those aspects of my personality I don't like.

Part 6: Impact of Events Scale (PTSD) (Weiss, 2007) (instructions modified from original)

Below is a list of difficulties people sometimes have after stressful life events. While thinking about your abuse experience(s), please read each item and indicate how distressing each difficulty has been for you during the past seven days. How much have you been distressed or bothered by these difficulties?

IMPACT OF EVENTS SCALE-Revised (IES-R)

INSTRUCTIONS: Below is a list of difficulties people sometimes have after stressful life events. Please read each item, and then indicate how distressing each difficulty has been for you DURING THE PAST SEVEN DAYS with respect to _____ (event)

that occurred on _____ (date). How much have you been distressed or bothered by these difficulties?

	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Any reminder brought back feelings about it	0	1	2	3	4
2. I had trouble staying asleep	0	1	2	3	4
3. Other things kept making me think about it.	0	1	2	3	4
4. I felt irritable and angry	0	1	2	3	4
5. I avoided letting myself get upset when I thought about it or was reminded of it	0	1	2	3	4
6. I thought about it when I didn't mean to	0	1	2	3	4
7. I felt as if it hadn't happened or wasn't real.	0	1	2	3	4
8. I stayed away from reminders of it.	0	1	2	3	4
9. Pictures about it popped into my mind.	0	1	2	3	4
10. I was jumpy and easily startled.	0	1	2	3	4
11. I tried not to think about it.	0	1	2	3	4
12. I was aware that I still had a lot of feelings about it, but I didn't deal with them.	0	1	2	3	4
13. My feelings about it were kind of numb.	0	1	2	3	4
14. I found myself acting or feeling like I was back at that time.	0	1	2	3	4
15. I had trouble falling asleep.	0	1	2	3	4
16. I had waves of strong feelings about it.	0	1	2	3	4
17. I tried to remove it from my memory.	0	1	2	3	4
18. I had trouble concentrating.	0	1	2	3	4
19. Reminders of it caused me to have physical reactions, such as sweating, trouble breathing, nausea, or a pounding heart.	0	1	2	3	4
20. I had dreams about it.	0	1	2	3	4
21. I felt watchful and on-guard.	0	1	2	3	4
22. I tried not to talk about it.	0	1	2	3	4

Total IES-R Score: _____

INT: 1, 2, 3, 6, 9, 14, 16, 20
 AVD: 5, 7, 8, 11, 12, 13, 17, 22
 HYP: 4, 10, 15, 18, 19, 21

Weiss, D.S. (2007). The Impact of Event Scale-Revised. In J.P. Wilson, & T.M. Keane (Eds.) *Assessing psychological trauma and PTSD: a practitioner's handbook* (2nd ed., pp. 168-189). New York: Guilford Press.

Part 7: Beck Depression Inventory-II (Beck, 1996)

	Beck Depression Inventory	Baseline
V 0477	CRTN: _____ CRF number: _____	Page 14 patient initials: _____
		Date: _____
Name: _____ Marital Status: _____ Age: _____ Sex: _____ Occupation: _____ Education: _____		
Instructions: This questionnaire consists of 21 groups of statements. Please read each group of statements carefully, and then pick out the one statement in each group that best describes the way you have been feeling during the past two weeks, including today. Circle the number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you do not choose more than one statement for any group, including Item 16 (Changes in Sleeping Pattern) or Item 18 (Changes in Appetite).		
1. Sadness 0 I do not feel sad. 1 I feel sad much of the time. 2 I am sad all the time. 3 I am so sad or unhappy that I can't stand it. 2. Pessimism 0 I am not discouraged about my future. 1 I feel more discouraged about my future than I used to be. 2 I do not expect things to work out for me. 3 I feel my future is hopeless and will only get worse. 3. Past Failure 0 I do not feel like a failure. 1 I have failed more than I should have. 2 As I look back, I see a lot of failures. 3 I feel I am a total failure as a person. 4. Loss of Pleasure 0 I get as much pleasure as I ever did from the things I enjoy. 1 I don't enjoy things as much as I used to. 2 I get very little pleasure from the things I used to enjoy. 3 I can't get any pleasure from the things I used to enjoy. 5. Guilty Feelings 0 I don't feel particularly guilty. 1 I feel guilty over many things I have done or should have done. 2 I feel quite guilty most of the time. 3 I feel guilty all of the time.	6. Punishment Feelings 0 I don't feel I am being punished. 1 I feel I may be punished. 2 I expect to be punished. 3 I feel I am being punished. 7. Self-Dislike 0 I feel the same about myself as ever. 1 I have lost confidence in myself. 2 I am disappointed in myself. 3 I dislike myself. 8. Self-Criticalness 0 I don't criticize or blame myself more than usual. 1 I am more critical of myself than I used to be. 2 I criticize myself for all of my faults. 3 I blame myself for everything bad that happens. 9. Suicidal Thoughts or Wishes 0 I don't have any thoughts of killing myself. 1 I have thoughts of killing myself, but I would not carry them out. 2 I would like to kill myself. 3 I would kill myself if I had the chance. 10. Crying 0 I don't cry anymore than I used to. 1 I cry more than I used to. 2 I cry over every little thing. 3 I feel like crying, but I can't.	



Beck Depression Inventory

Baseline

V 0477

CRTN: _____ CRF number: _____

Page 15 patient initials: _____

11. Agitation

- 0 I am no more restless or wound up than usual.
- 1 I feel more restless or wound up than usual.
- 2 I am so restless or agitated that it's hard to stay still.
- 3 I am so restless or agitated that I have to keep moving or doing something.

12. Loss of Interest

- 0 I have not lost interest in other people or activities.
- 1 I am less interested in other people or things than before.
- 2 I have lost most of my interest in other people or things.
- 3 It's hard to get interested in anything.

13. Indecisiveness

- 0 I make decisions about as well as ever.
- 1 I find it more difficult to make decisions than usual.
- 2 I have much greater difficulty in making decisions than I used to.
- 3 I have trouble making any decisions.

14. Worthlessness

- 0 I do not feel I am worthless.
- 1 I don't consider myself as worthwhile and useful as I used to.
- 2 I feel more worthless as compared to other people.
- 3 I feel utterly worthless.

15. Loss of Energy

- 0 I have as much energy as ever.
- 1 I have less energy than I used to have.
- 2 I don't have enough energy to do very much.
- 3 I don't have enough energy to do anything.

16. Changes in Sleeping Pattern

- 0 I have not experienced any change in my sleeping pattern.
- 1a I sleep somewhat more than usual.
- 1b I sleep somewhat less than usual.
- 2a I sleep a lot more than usual.
- 2b I sleep a lot less than usual.
- 3a I sleep most of the day.
- 3b I wake up 1-2 hours early and can't get back to sleep.

17. Irritability

- 0 I am no more irritable than usual.
- 1 I am more irritable than usual.
- 2 I am much more irritable than usual.
- 3 I am irritable all the time.

18. Changes in Appetite

- 0 I have not experienced any change in my appetite.
- 1a My appetite is somewhat less than usual.
- 1b My appetite is somewhat greater than usual.
- 2a My appetite is much less than before.
- 2b My appetite is much greater than usual.
- 3a I have no appetite at all.
- 3b I crave food all the time.

19. Concentration Difficulty

- 0 I can concentrate as well as ever.
- 1 I can't concentrate as well as usual.
- 2 It's hard to keep my mind on anything for very long.
- 3 I find I can't concentrate on anything.

20. Tiredness or Fatigue

- 0 I am no more tired or fatigued than usual.
- 1 I get more tired or fatigued more easily than usual.
- 2 I am too tired or fatigued to do a lot of the things I used to do.
- 3 I am too tired or fatigued to do most of the things I used to do.

21. Loss of Interest in Sex

- 0 I have not noticed any recent change in my interest in sex.
- 1 I am less interested in sex than I used to be.
- 2 I am much less interested in sex now.
- 3 I have lost interest in sex completely.

3456789101112ABCDE

Subtotal Page 2

Subtotal Page 1

Total Score

NR15645

Part 8: Trauma-Related Guilt Inventory (Kubany 1996)

TRAUMA-RELATED GUILT INVENTORY

Appendix

Trauma-Related Guilt Inventory

Copyright © 1993 by Edward S. Kubany

Response to Trauma (Version All)

Individuals who have experienced traumatic events—such as physical or sexual abuse, military combat, sudden loss of loved ones, serious accidents or disasters, etc.—vary considerably in their response to these events. Some people do not have any misgivings about what they did during these events, whereas other people do. They may have misgivings about something they did (or did not do), about beliefs or thoughts they had, or for having had certain feelings (or lack of feelings). The purpose of this questionnaire is to evaluate your response to a traumatic experience.

Briefly describe what happened:

Please take a few moments to think about what happened. All the items below refer to events related to this experience. Circle the answer that best describes how you feel about each statement.

- | | | | | | |
|--|----------------|-----------------|----------------|---------------|-----------------|
| 1. I could have prevented what happened. | Extremely true | Very true | Somewhat true | Slightly true | Not at all true |
| 2. I am still distressed about what happened. | Always true | Frequently true | Sometimes true | Rarely true | Never true |
| 3. I had some feelings that I should not have had. | Extremely true | Very true | Somewhat true | Slightly true | Not at all true |
| 4. What I did was completely justified. | Extremely true | Very true | Somewhat true | Slightly true | Not at all true |
| 5. I was responsible for causing what happened. | Extremely true | Very true | Somewhat true | Slightly true | Not at all true |
| 6. What happened causes me emotional pain. | Always true | Frequently true | Sometimes true | Rarely true | Never true |
| 7. I did something that went against my values. | Extremely true | Very true | Somewhat true | Slightly true | Not at all true |
| 8. What I did made sense. | Extremely true | Very true | Somewhat true | Slightly true | Not at all true |
| 9. I knew better than to do what I did. | Extremely true | Very true | Somewhat true | Slightly true | Not at all true |
| 10. I feel sorrow or grief about the outcome. | Always true | Frequently true | Sometimes true | Rarely true | Never true |
| 11. What I did was inconsistent with my beliefs. | Extremely true | Very true | Somewhat true | Slightly true | Not at all true |
| 12. If I knew today—only what I knew when the event(s) occurred—I would do exactly the same thing. | Extremely true | Very true | Somewhat true | Slightly true | Not at all true |
| 13. I experience intense guilt that relates to what happened. | Always true | Frequently true | Sometimes true | Rarely true | Never true |
| 14. I should have known better. | Extremely true | Very true | Somewhat true | Slightly true | Not at all true |
| 15. I experience severe emotional distress when I think about what happened. | Always true | Frequently true | Sometimes true | Rarely true | Never true |
| 16. I had some thoughts or beliefs that I should not have had. | Extremely true | Very true | Somewhat true | Slightly true | Not at all true |

KUBANY ET AL.

17. I had good reasons for doing what I did.	Extremely true	Very true	Somewhat true	Slightly true	Not at all true
18. Indicate how frequently you experience guilt that relates to what happened.	Never	Seldom	Occasionally	Often	Always
19. I blame myself for what happened.	Extremely true	Very true	Somewhat true	Slightly true	Not at all true
20. What happened causes a lot of pain and suffering.	Extremely true	Very true	Somewhat true	Slightly true	Not at all true
21. I should have had certain feelings that I did not have.	Extremely true	Very true	Somewhat true	Slightly true	Not at all true
22. Indicate the intensity or severity of guilt that you typically experience about the event(s).	None	Slight	Moderate	Considerable	Extreme
23. I blame myself for something I did, thought, or felt.	Extremely true	Very true	Somewhat true	Slightly true	Not at all true
24. When I am reminded of the event(s), I have strong physical reactions such as sweating, tense muscles, dry mouth, etc.	Always true	Frequently true	Sometimes true	Rarely true	Never true
25. Overall, how guilty do you feel about the event(s)?	Not guilty at all	Slightly guilty	Moderately guilty	Very guilty	Extremely guilty
26. I hold myself responsible for what happened.	Extremely true	Very true	Somewhat true	Slightly true	Not at all true
27. What I did was not justified in any way.	Extremely true	Very true	Somewhat true	Slightly true	Not at all true
28. I violated personal standards of right and wrong.	Extremely true	Very true	Somewhat true	Slightly true	Not at all true
29. I did something that I should not have done.	Extremely true	Very true	Somewhat true	Slightly true	Not at all true
30. I should have done something that I did not do.	Extremely true	Very true	Somewhat true	Slightly true	Not at all true
31. What I did was unforgivable.	Extremely true	Very true	Somewhat true	Slightly true	Not at all true
32. I didn't do anything wrong.	Extremely true	Very true	Somewhat true	Slightly true	Not at all true

Part 9: Confirmation of data usage

(Check box): I confirm that I am okay with the anonymous data from this survey being used in future scientific publications and presentations.

End message:

Thank you for your participation in this study; we really value your input and time. The results of this study will be published on the [redacted] website. If you have any questions or concerns, please email Shaakya Vembar at: vembars@tcd.ie

Appendix I: Quantitative Study Recruitment Poster for Migrant Women's Service**HAVE YOU EXPERIENCED ANY OF THESE IN YOUR CHILDHOOD (WHEN YOU WERE YOUNGER THAN 18):**

- Unwanted sexual contact by someone in your age group
- Sexual contact by an adult (e.g. penetration, touching of genitals, forcing you to touch genitals, insertion of objects into genitals)
- Exposure to pornography by an adult
- Witnessing people perform sexual acts
- Female genital mutilation (FGM)
- Exposure of someone's genitals or sexual acts via cellphone or social media outlets
- Or something similar...

AND ARE YOU CURRENTLY IN COUNSELLING/THERAPY?

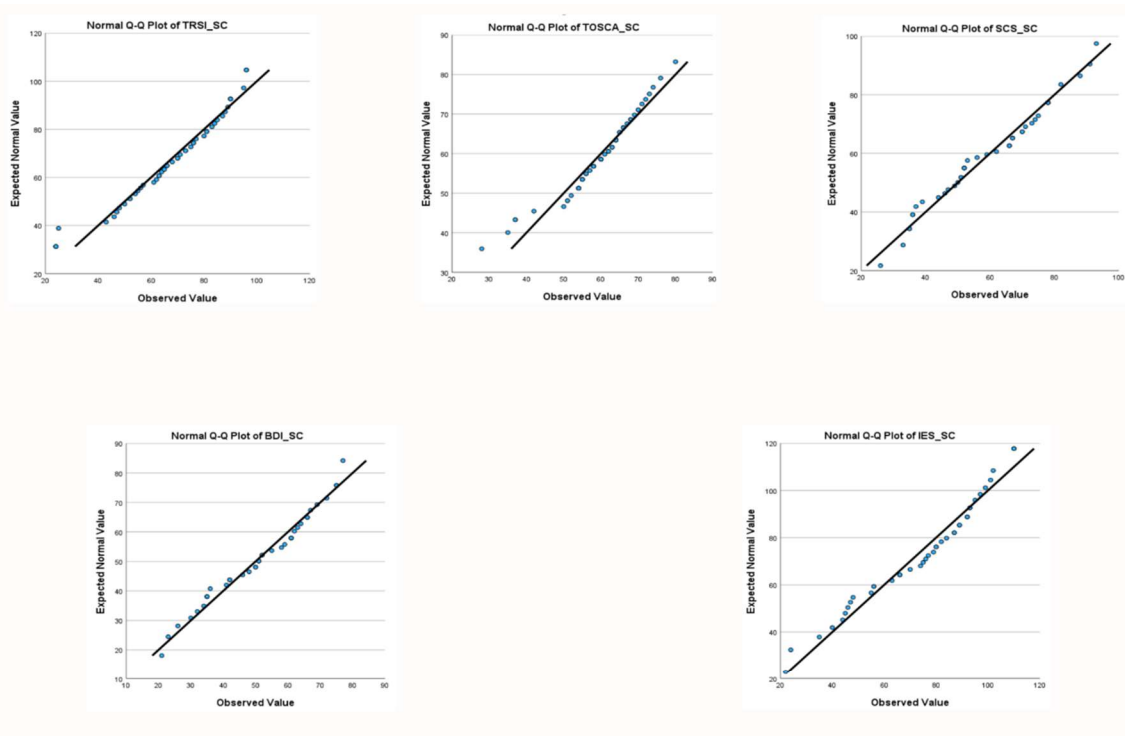
[redacted] and Trinity College Dublin are conducting an ANONYMOUS SURVEY about people with these experiences.

If you are over 18 and interested in taking the survey, please follow this link:

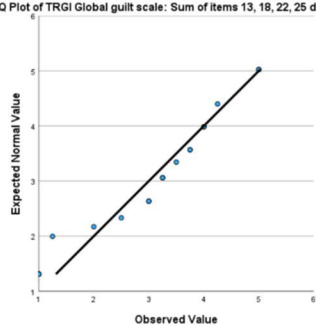
If you have any questions, feel free to contact us at:

[redacted]
vembarsetcd.ie

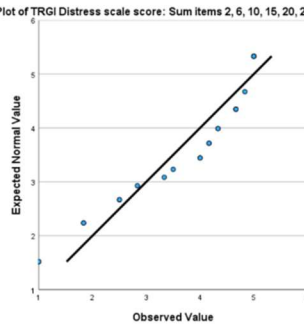
Appendix J: Q-Q Plots for Outcome Measures



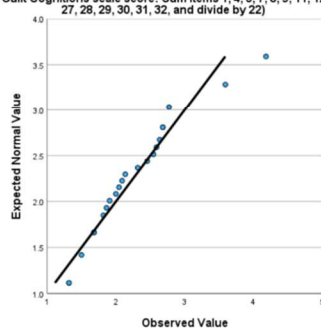
Normal Q-Q Plot of TRGI Global guilt scale: Sum of items 13, 18, 22, 25 divided by 4



Normal Q-Q Plot of TRGI Distress scale score: Sum items 2, 6, 10, 15, 20, 24 divided by 6)



Normal Q-Q Plot of TRGI Guilt Cognitions scale score: Sum items 1, 4, 5, 7, 8, 9, 11, 12, 14, 16, 17, 19, 21, 23, 26, 27, 28, 29, 30, 31, 32, and divide by 22)



Appendix K: Qualitative Study Overall Ethics Approval Letter (2023)



Coláiste na Tríonóide, Baile Átha Cliath
Trinity College Dublin
Ollscoil Átha Cliath | The University of Dublin

Shaakya Vembar,
Department of Psychiatry,
Trinity College Dublin, The University of
Dublin Dublin 2
Ireland

28th April 2023

Ref: 211205

Title of Study: Exploring Shame in Adult Survivors of Child Sexual Abuse

Dear Shaakya,

Further to a meeting of the Faculty of Health Sciences Ethics Committee held in April 2023. We are pleased to inform you that the above project has ethical approval to proceed.

This study has been ethically approved. We would advise you to seek review and comments on your DPIA from the DPO if required prior to study commencement.

As a researcher you must ensure that you comply with other relevant regulations, including DATA PROTECTION and HEALTH AND SAFETY.

We wish you every success with this study and should you require any assistance in the future please do not hesitate to contact us.

Yours sincerely,

Prof. Jacintha O'Sullivan
Chairperson
Faculty Research Ethics Committee

Appendix L: Qualitative Study Ethical Approval Letter for Service Provider Interviews



Coláiste na Tríonóide, Baile Átha Cliath
Trinity College Dublin
Ollscoil Átha Cliath | The University of Dublin

Shaakya Vembar,
Department of Psychiatry,
Trinity College Dublin, The University of Dublin,
Dublin 2
Ireland

9th November 2023

Ref: 211205
Title of Study: Exploring Shame in Adult Survivors of Child Sexual Abuse

Dear Shaakya,

Further to a meeting of the Faculty of Health Sciences Ethics Committee held in November 2023, we are pleased to inform you that the above project (as amended with the following changes) has ethical approval to proceed.

Please give specific details of the requested amendment(s):

Our study #211205 aims to better understand potential experiences of shame felt by adult survivors of child sexual abuse. This is being done by undertaking qualitative semi-structured interviews. Our original protocol, approved by this REC, involved recruiting adult survivors of child sexual abuse, through [REDACTED] to take part in interviews about potential experiences of shame related to their abuse.

However, we have only been able to recruit and interview two individuals through [REDACTED] which provides insufficient data for our analyses.

We are hence proposing to amend our study protocol to also interview qualified service providers who work with adult survivors of child sexual abuse. We anticipate that this will provide valuable further indirect data about the experience of shame in adult survivors of child sexual abuse.

Service providers will be recruited through two [REDACTED] the organization from which we have been recruiting survivors. The second [REDACTED] which provides a national support network for migrant women living in Ireland. We are also already currently [REDACTED] in relation to a separate study (study #210403) involving survivors of child sexual abuse completing anonymous online questionnaires.

Although all protocols involving data protection remain the same for this study, a number of study materials require adapting for our interviews with service providers.

Along with this amendment, we have attached:

1. An updated Participant Information Leaflet ('Service Provider Interview PIL').
2. An updated Consent Form ('Service Provider Interview Consent Form').
3. An updated Invitation Email, to be circulated to [REDACTED] ('Service Provider Interview Invitation Email').
4. An updated interview schedule ('Service Provider Interview Schedule').

We have also attached letters of support from [REDACTED] evidencing their support for the study and willingness to internally advertise the study to relevant service providers.

All changes to the originally approved materials have been made in Track Changes, so the Chair can see how we have adapted the materials

As a researcher you must ensure that you comply with other relevant regulations, including DATA PROTECTION and HEALTH AND SAFETY.

Yours sincerely,



Prof. Jacintha O'Sullivan
Chairperson Faculty Research Ethics Committee

AMENDMENT

Appendix M: Qualitative Study Consent Form Example

INFORMED CONSENT FORM

STUDY NAME: Exploring Shame in Adult Survivors of Child Sexual Abuse

Dear Participant,

There are two sections in this form. The first section has several statements and asks you to tick if you have understood the information provided to you in the Participant Information Leaflet. This is to make sure you understand what this research project is about (that you are informed). The second section asks for your consent. Please tick each of the boxes if you agree to take part.

Please tick box if you agree with each statement. Please feel free to ask Shaakya questions if there is something you do not understand.

General	Tick box
1. I confirm I have read and understood the Participant Information Leaflet for the above study. The information has been fully explained to me, and I have been able to ask questions, all of which have been answered to my satisfaction.	
2. I understand that this study is entirely voluntary, and if I decide that I do not want to take part, I can stop taking part in this study without giving a reason, at any point during the study	
3. I understand that I will not get paid.	
4. I understand that I will take part in an interview that will last around 60 minutes with the audio (but not video) being recorded.	
5. I understand that during the interview, I do not have to answer questions that make me uncomfortable.	
6. I understand that I will be contacted once after the interview via email, by Shaakya. She will ask me if I want to review the transcript of the interview (typed up version). I understand that I will have two weeks to get back to Shaakya if I want to make any changes to the interview transcript. I understand I do not have to review the transcript if I don't want to. I understand that if I do not respond, Shaakya will analyse the transcript as is.	
7. I understand that I can request the deletion of my original interview transcript) up until September 15th, 2023.	
8 I understand that, as explained in the information sheet, there are some situations in which the research will be obliged to break confidentiality.	
9 I know how to contact the research team if I need to.	
Consent	Tick box

1. I consent to take part in this research study, having been fully informed of the risks and benefits, which are set out in full in the information leaflet which I have been provided with.	
2. I consent to the use my personal data (audio recording and the information I provide during the interview) for this research.	

Name:

Signature:

Date:

Witness Name: (Block Capitals)

Witness Signature:

Date

To be completed by the main researcher:

I, the undersigned, have taken the time to fully explain to the above participant the nature and purpose of this study in a way that they could understand. I have explained the risks and possible benefits involved. I have invited them to ask questions on any aspect of the study that concerned them.

I have given a copy of the information leaflet and consent form to the participant with contacts of the study team

Researcher name:

Signature:

Date:

Appendix N: Qualitative Study Participant Information Leaflet Example

Participant Information Leaflet

The purpose of this information sheet is to provide you with information about this research project, and to inform you of certain requirements under data protection, so that you can decide whether to take part in the study.

If you have any queries or require any further information, please get in touch with Shaakya Vembar at vembars@tcd.ie

Name of Study: EXPLORING SHAME IN ADULT SURVIVORS OF CHILD SEXUAL ABUSE

Principal Investigator(s) and Co-Investigator(s)	1. Shaakya Vembar (PhD Student, Department of Psychiatry, Trinity College Dublin); vembars@tcd.ie 2. Dr. Simon McCarthy-Jones (Trinity Centre for Health Sciences, St. James' Hospital); mccartsi@tcd.ie 3. Dr. Elizabeth Nixon (School of Psychology, Trinity College Dublin); enixon@tcd.ie
Data Controller	Trinity College Dublin
Data Protection Officer	Data Protection Officer Secretary's Office Trinity College Dublin Dublin 2 Email: dataprotection@tcd.ie

You are being invited to take part in a research study that is being carried out by Trinity College Dublin in collaboration with [redacted].

The lead researcher Shaakya Vembar, is doing this research for her PhD in the Department of Psychiatry at Trinity College Dublin,

Before you decide whether you wish to take part, please read this information sheet carefully. You can email Shaakya or [redacted] to ask any questions before the interview begins. Don't feel rushed or under pressure to make a quick decision. You should understand the risks and benefits of taking part in this study so that you can make the decision that is right for you. You may wish to discuss it with your family, friends, or [redacted] clinician.

This leaflet has five main parts:

- Part 1 – The Study
- Part 2 – Data Protection
- Part 3 – Costs, Funding and Approval
- Part 4 – Future Research
- Part 5 – Further Information

Who are we?

Trinity College Dublin is doing this study. Two senior academics in the Department of Psychiatry (Dr. Simon McCarthy-Jones) and the School of Psychology (Dr. Elizabeth Nixon) at Trinity College Dublin are supervising Shaakya, who is the PhD student conducting the study.

What is this study about?

We want to explore the potential feeling of shame in adult survivors of child sexual abuse to better address survivors' needs in a clinical setting. We plan to use the themes that emerge from the interviews to inform the creation of a new scale measuring shame in child sexual abuse survivors. To do this we are conducting in-depth interviews with survivors.

Why is this study being done?

Shame is a common consequence of child sexual abuse and can last for many years or decades after the abuse. We know that abuse-related shame is linked to other negative effects, such as post-traumatic stress disorder and negative physical effects. However, there isn't a lot of research into shame when it comes to child sexual abuse, so this study aims to add to that field. It is important that we learn how to prevent and reduce shame in survivors so that other long-term negative consequences can be avoided too.

Why have I been asked to take part?

You have been invited to take part in an interview as you are currently in the care of [redacted], as an adult who has suffered child sexual abuse.

Do I have to take part?

You do not have to take part. Giving the interview is completely voluntary, and you will not face any negative consequences for not taking part. Your decision not to take part will in no way affect your relationship with [redacted].

What does taking part involve?

First, you will be asked for your consent to participate in this study. You should feel no pressure to take part and can also withdraw your participation at any point during the interview if you so choose.

If you decide to take part, you will be asked to email Shaakya to schedule your interview. The interview will be scheduled on a weekday during business hours (between 9am and 5pm).

The interview will take place either in person (at Trinity College Dublin), or online over Microsoft Teams, depending on your preference. In both cases (face-to-face or online), The interview will take roughly 60 minutes and will be audio-recorded on Microsoft Teams with your permission. NO VIDEO will be recorded.

In the interview we will ask you questions about your emotional and social experiences related to your past abuse. You will be asked to talk about how you felt, currently feel, how people around you reacted and currently react to the knowledge of the abuse (and how this made/makes you feel). You may go into as much or as little detail as you are comfortable with when asked these

questions--there is no correct answer or response length. You do not have to answer any questions that make you uncomfortable. You will be asked to try and not mention any specific names or locations during the interview for data protection reasons; where names or locations are mentioned, these details will be removed from the transcript within 24 hours. You do not

have to go into detail about the abuse itself, but **please keep in mind that due to the nature of the interview you will be asked to think back to the abuse.**

Can I change my mind?

Yes, you can change your mind at any time, and you do not have to give a reason.

You can also stop giving the interview at any point without any negative consequences, and all information you have provided will be permanently deleted.

What will happen to the information?

The information you give us will be used as part of a PhD project, which means it will be analysed and published in journal articles and presentations. No information that could identify you will be included in any publications.

Audio recordings of the interview will be stored securely on systems provided by Trinity College with access only to members of the research team listed on this information leaflet. After the interview, the lead researcher, Shaakya, will write down a transcript of the interview, and edit it to take out references to specific people and places that could identify you or others. At this point she will delete the audio recording. She will email you to ask if you would like to read it through. You do not have to review your transcript if you do not wish to. If you choose to review the transcript, you will be given two weeks for accuracy-checking or to suggest any other changes you want to make (for example if you want to take out any information given during the interview). If you do not respond to the email requesting you to review the transcript within two weeks, the lead researcher will go ahead and analyse the transcript as is.

You can still choose to withdraw your data (i.e., the entire interview transcript) from the study until September 15th, 2023. If you choose to withdraw your data from the study, we will delete all information about you. After September 15th, 2023, it will not be possible to withdraw your data anymore, as we will permanently delete the re-identification key (and consent forms) on this date, which will make us unable to link your interview transcript to your identity.

The research study information, including consent forms and transcripts will only be accessible to the research team members listed at the start of this Participant Information Leaflet.

What are the risks associated with participating?

There is a risk of experiencing emotional distress during the interview due to recalling your child sexual abuse experience(s). You may also experience dissociation, flashbacks, or anxiety in the weeks after taking part in the study. Please take some time to consider whether you anticipate any distress when talking about topics relating to your abuse. Please bear in mind that you may stop the interview at any time. If you experience distress at any point, please let Shaakya know and if you wish, the interview will be terminated at this point and your data will not be used.

A list of organisations that offer support is available at the end of this leaflet. You can also speak with your therapist in [redacted] and reflect on your interview experience.

We would recommend that if you feel like you would experience a high level of distress, PLEASE DO NOT PARTICIPATE IN THE STUDY.

Please note that Shaakya is not qualified to provide clinical support in case of distress.

Will I get feedback or be told the outcome of the study?

Results of the study will be presented via [redacted]'s media (blogs, social media, etc.) once data collection and analysis has ended. The results of this research will be included in the thesis being undertaken by Shaakya Vembar as part of her Ph.D. academic qualification. The results of the

research will be disseminated in scientific journals. No information that might identify individuals will be included in any publication. We will not be able to provide individual feedback.

How will this research benefit me?

You will not benefit directly from taking part in this research project. Your contribution will be aggregated (grouped) and the findings from the research study will, on a broader level, offer benefits in terms of providing greater understanding of how shame may affect survivors.

What information about me (personal data) will be used as part of this study?

We will need your name and contact details to arrange the interview, and to share the transcript with you.

During the interview, we will ask you some information about your age, relationship status, occupation, ethnicity, and your age at time of abuse. We will ask you to talk about your experiences of child sexual abuse as well.

Will my personal data be kept confidential?

Your privacy is important to us. We take many steps to keep any information you share with us safe. Several safeguards are in place to protect your privacy and to ensure the security of the research data. Here are some examples of how we do this:

- Your name and any identifiable information will be removed and replaced with a code to protect your identity. The key to link back to your identity will be kept securely and separately from other research information, and only known to Shaakya.
- Access to data is limited to the research team named at the beginning of this leaflet.
- Only secure storage systems are used which have been approved by Trinity IT Services Researchers complete (GDPR) training provided by Trinity College Dublin.
- Researchers who have access to personal data are bound by a professional code of confidentiality.

Exceptions to confidentiality

The only exceptions to maintain the confidentiality of your interview and transcript are:

- 1) If we receive information about previously unreported child abuse and maltreatment, we are required to break participant-researcher confidentiality. The researcher will have a professional and legal obligation to report it to [redacted] and they will inform relevant authorities.
- 2) If you disclose wanting to harm yourself. We will need to report this to a clinician at [redacted] for your safety.
- 3) Discussion of unreported or intended criminal activity could be subject to request for access from the Gardaí or a warrant or a court order.

What is the lawful basis to use my personal data?

We will only use the personal data outlined above (audio recording, transcript, opinions from the interview etc.) for this research study¹ or if needed to comply with a legal obligation² or in the establishment, exercise, or defense of a legal claim³.

What are my rights?

Under the GDPR, you can exercise the following rights in relation to the information you provide unless the request would make it impossible or very difficult to conduct the research. You can request

- to access your data and receive a copy of it
 - to have any inaccuracies corrected, and you can restrict or object to our use whilst we correct this information
 - the deletion of your data
- unless the request would make it impossible or very difficult to conduct the research.

Please note that the right to delete and/or amend your data only applies until we break the link between your identity and your transcript, on September 15th, 2023.

You can contact the researcher or the Trinity College Data Protection Officer, Secretary's Office, Trinity College Dublin, Dublin 2, Ireland. Email: dataprotection@tcd.ie. Website: www.tcd.ie/privacy.

Under GDPR, if you are not satisfied with how your data is being processed, you have the right to raise a concern with the Office of the Data Protection Commission, 21 Fitzwilliam Square South, Dublin 2, Ireland. Website: www.dataprotection.ie.

Has this study been approved by a research ethics committee?

This study has been approved by the Faculty of Health Sciences Research Ethics Committee at Trinity College Dublin. Approval was granted on [April 28th, 2023].

Who is organising and funding this study?

This research is being organised by Shaakya Vembar who is conducting this research for the purposes of obtaining an academic qualification. The study is funded by Trinity College Dublin.

Will I be paid for taking part? Will it cost anything to take part?

There is no payment for participation in this study, nor are there any costs.

Will the data be used in future studies?

The data collected in this study will only be used for publications by Shaakya and the research team named above, and for Shaakya's PhD thesis due to be submitted by the end of 2023.

Who should I contact for information or concerns?

If you have any concerns or questions, you can contact:

- **Principal Investigator: Shaakya Vembar**, Department of Psychiatry, Trinity College, Dublin 2. Email: vembars@tcd.ie

- *Data Protection Officer, Trinity College Dublin: Data Protection Officer, Secretary's Office, Trinity College Dublin, Dublin 2, Ireland. Email: dataprotection@tcd.ie. Website: www.tcd.ie/privacy.*

What should I do now?

At this point you should think about whether you want to take part in an interview. Take your time and re-read the information leaflet if you feel like and ask any questions you may have (you can contact either Shaakya or [redacted]).

If you would like to participate, please send an email to Shaakya at vembars@tcd.ie. Shaakya will then send you a consent form and ask you to indicate your availability for the interview.

If you don't want to participate, thank you for taking the time to read this information leaflet and you don't have to do anything else.

Support Services:

Here are contact details of support services you may wish to contact in case of distress:

- 1) One in Four: 01 66 24070
- 2) Rape Crisis Help: 1800 77 8888
- 3) Men's Aid Ireland: 01 554 3811
- 4) Samaritans Ireland: 116 123

Appendix O: Qualitative Study Survivor Invitation Letter

Invitation Email

Dear [insert name here],

You are receiving this email as you are currently engaged with [redacted]'s services.

We are writing to invite you to take part in a research project being conducted by Trinity College Dublin in collaboration with [redacted].

We would like to interview adult survivors of child sexual abuse to try to understand better your potential experiences of feeling shame so that we can improve clinical care, and eventually create a new scale to measure shame in child sexual abuse survivors.

These interviews are being done by Shaakya Vembar, a PhD student at Trinity College Dublin, under the supervision of Dr Simon McCarthy-Jones and Dr Elizabeth Nixon, and in collaboration with [redacted].

Full details of the research can be found in the attached Participant Information Leaflet. If you are interested in taking part in this study, please read the attached Information Leaflet and Consent Form carefully.

If you have any questions, you can email me [redacted] or Shaakya (vembars@tcd.ie).

There is a risk that you will experience mental distress during the interview as we will talk about the sexual abuse you experienced as a child. If you feel like you would experience a high level of distress, PLEASE DO NOT PARTICIPATE IN THE STUDY.

If you choose to take part, the interview will take place during business hours (between 9am and 5pm) at a time that suits you, so that in case of distress, you will be able to contact somebody from [redacted] or another organisation for immediate help.

Please note that Shaakya is not qualified to provide clinical support in case of distress.

If after reading the attached information you are interested in participating in an interview with Shaakya, please email her at: vembars@tcd.ie. We recommend that you take your time to consider if you would like to take part.

The interviews will be running for the next three months.

If you decide NOT to take part, you can just ignore this email. Your decision not to take part will in no way affect your relationship with [redacted].

Yours sincerely,

[redacted]

Appendix P: Qualitative Study Survivor Interview Schedule

Interview Schedule

Part 1: Introduction of interviewer and study

- Hi, I'm Shaakya, a PhD student at TCD....
- Background of study, goals, benefits
- Mandated reporting

Part 2: Questions about how the participant has been feeling/doing recently

- So how have you been doing generally these past few weeks?
 - Probes in case of short response:
 - What kinds of emotions have you been feeling?
 - What kinds of thoughts do you tend to have?

Part 3: Emotional responses (past and present)

- If you're ok with doing so, I'm going to ask you to think back to when you were younger, around the time of your abuse. Would you be ok with doing that now?
 - *If yes: I'm interested in what it is like for an adult who has experienced childhood sexual abuse to experience shame about their CSA in childhood and adulthood. It may be that you have not experienced shame at all, which I would also be interested in learning about. I'd like to hear your story of that experience. You can start at whatever point you wish, I won't interrupt or say anything throughout and will only listen and take some brief notes for some follow up questions later."*
 - Did you tell anyone about the abuse, why or why not?
 - *If yes:* Could you tell me about how you felt around the time you disclosed your abuse?
 - How did you feel about yourself as a person before and after the disclosure?
 - *Probes:*
 - How would you describe your opinion of yourself at the time?
 - *Ask about shame if never mentioned.*
- How do you feel these days when you think about your abuse?
 - How do you feel about yourself?
 - How do you feel about your abuser?
 - How would you describe yourself as a person today?

Part 4: Familial responses (past and present)

- I'm going to switch gears a little and ask you about your family and their feelings/responses to your abuse now.
 - Could you tell me about your family's actions or reactions around the time of your abuse?
 - What was your relationship with your parents/guardians and/or siblings like before and after the abuse started?
 - *In case abuse was disclosed:* How did your family members react once you disclosed the abuse? Did they treat you differently?
 - *Probes:* What kinds of things did they say to you or others?
 - Could you talk about what your relationship with your family (parents/siblings/etc.) is like today?

Part 5: General social/community responses (past and present)

- This part of the interview is about how your community and your general social environment responded to your abuse.
 - Could you describe what your wider community was like at the time of your abuse (e.g. what your neighborhood, town, or school was like, was it tight-knit, distant, etc.)

- Were there community members who were aware of the abuse?
 - *Is yes: How did those people respond?*
 - How did they treat you after finding out?
 - How did you feel about them (and the way they responded to your abuse)?
- How would you say your community affected the way you felt about your abuse and about yourself?

Part 6: Other Topics & Follow-Ups

- Is there anything else you would like to talk about?
- *Follow up on things they have said that might need elaboration*

Part 7: Conclusion

- *Check with participant if they are ok, experiencing distress, etc.*
- *Ask about plans for the rest of the day*
- *Thank yous and reiteration of consent*

Appendix Q: Qualitative Study Service Provider Interview Schedule

Service Provider Interview Schedule

Part 1: Introduction of interviewer and study

- Hi, I'm Shaakya, a PhD researcher at TCD....
- Background of study, goals, benefits
- Mandated reporting

Part 2: Background of Service Provider and Current Clientele

- Could you briefly describe your work and educational background?
- Could you describe in general terms the clientele you currently work with?
 - *(e.g.: what do they generally present with, what regions of the world/country do they tend to be from, age range, gender, etc.)*
- Could you describe your current work methodologies and approaches when working with clients with CSA/FGM histories?
 - What would you say are some essential steps for clinicians and other service providers when addressing CSA-related shame?
- With regard to shame (or guilt, or self-blame,) how would you say you see this manifest in your clients?
 - *Follow-up questions to be formulated based on participant responses*
- What are some of the major consequences or effects of shame you've observed in your clients?
 - *Follow-up questions to be formulated based on participant responses*

Part 3: Service Providers' Understanding of Shame, Guilt, and Self-Blame

- In your own words, how would you describe shame, both in clinical and non-clinical contexts?
- How would you differentiate shame and self-blame?
- How would you differentiate shame and guilt?

Part 3: Elaboration on Approaches to Shame

- Continuing on from your earlier responses: could you go into more detail about how you tend to identify shame in clients? *(e.g. do they use measurement tools, key words mentioned, etc.?)*
 - When clients are not able to name or explicitly identify their CSA-related shame, what is your approach to this situation?
 - Are there any body-language-related signs you tend to see in clients with high levels of shame?
- How important do you think it is for clients to identify and address their shame as part of the healing process, and why?
- Could you elaborate on the therapeutic/clinical approaches you have used to engage with clients' CSA-related shame, and how clients generally respond to these approaches?
- What are some challenges you've found in addressing/talking about shame relating to clients' CSA experiences?
 - *Follow-up questions to be formulated based on participant responses*
- Could you describe some of the positive outcomes you have observed when clients engage with their shame?
 - *To what extent would you say overall recovery is possible in clients when shame is still a prevalent issue?*
- What are some of the more helpful practices you can recommend to other clinicians and service providers when it comes to helping clients 'release' their shame?

Part 4: Emotional Responses of Clients, Disclosure, and Generational Changes

- In your experience, do you find that clients generally have already identified and/or engaged with their shame and/or self-blame before they begin their counseling journey? Why or why not?
 - If not, have you observed any patterns regarding how clients respond or react when you first start addressing the shame?
- To the extent that you're able to, could you describe the typical trajectory of a client in terms of their relationship with shame, from the start to the end of their time with you?
 - *Clarification: If there is no discernible pattern,*
- In research to date, shame has been identified as a major factor preventing the disclosure of CSA, both in childhood and adulthood—in your experience what role have you seen shame play in the disclosure processes of survivors?
 - Is there a particular point in life, or a particular event, that led your clients to realise that what they experienced was abuse/wrong in some way?
- Have you noticed generational differences in the way clients feel shame and in the way they intellectually think about shame?
 - Have you noticed generational differences in the way clients engage with their shame in therapy?

Part 5: Familial and Community Responses to Survivors' CSA Experiences

- I'm going to switch gears a little and ask you about the role of (non-offending) family members in survivors' experiences of shame and guilt.
 - Could you tell me about how families of your clients have tended to react to the abuse?
 - What factors relating to their reactions have helped your clients?
 - What factors have hindered your clients' recovery?
 - Where the relationship between family members and your clients is *negative*, could you elaborate on why that is?
 - Where the relationship between family members and your clients is *positive*, could you elaborate on why that is?
 - *Same questions as above for wider community responses*
- In your opinion, what are some steps families and communities can take to aid survivors after the abuse, and to mitigate potential shame?

Part 6: Socio-Cultural Influences on Clients' CSA/Shame Experiences

- Could you describe how the cultural contexts of your clients might have influenced their experiences of shame and guilt?
 - What are some of the cultural factors that may have induced or mitigated their shame, both in childhood and adulthood?
- How do you as a service provider try to account for cultural factors that seem to increase shame in clients?
- What is your outlook regarding how the cultural factors you've mentioned are developing/changing, or will change in the near future? How might further research in this area help?

Part 7: Clinical Suggestions & Follow-Ups

- What would help you, as a service provider, in helping clients release their shame? This could be anything from clinical tools, awareness-raising campaigns, pushes for cultural shifts, governmental-level change, etc.
 - *Follow up questions to be formulated based on responses*
- Is there anything else you would like to talk about?
- *Follow up on things they have said that might need elaboration*

Part 8: Conclusion

- *Check with participant if they are ok, experiencing distress, etc.*
- *Thank yous and reiteration of consent*

