Incorporating Trauma-Informed Practices into Psychotherapeutic Supports for Adult Survivors of Child Sexual Abuse.

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Abstract

There appears to be increasing incorporation of Trauma Informed Practice (TIP) into psychotherapeutic supports for adult survivors of Child Sexual Abuse (CSA) in Ireland. Yet there are also reports of confusion about what TIP means, uncertainty about its practical implications, and considerable variability in the efficacy with which it is implemented. This has led to calls for increased provision of specialist sexual violence services that place trauma at their heart, addressing survivors' basic safety concerns and minimising the risk of re-traumatisation. This desk-based research study aims to inform and rekindle the debate around provision of TIP-informed services for adult survivors of CSA in Ireland. It synthesises literature that offers a rationale for TIP, and provides clients, psychotherapists, policy makers, and others with a sense of what effective incorporation looks like in the psychotherapeutic encounter. Findings suggest that, not only does TIP profoundly improve the quality and character of psychotherapy for CSA survivors, it is indispensable to this. Practical suggestions are made around how TIP can be used to create safer relational, psychological, and physical psychotherapeutic spaces.

Introduction

Despite positive reports of a general increase in the incorporation of TIP into Irish mental health and psychotherapeutic services, adult survivors of CSA report foregoing much needed treatment because they believe that these supports are too generic, fall far short of clients' basic safety requirements, and take insufficient account of the effects of complex trauma (Crockett, 2021). Elliott et al. (2020) believe that traditional service models (inadvertently) continue to replicate the power imbalances that pertained to environments in which CSA occurred, increasing the risk of client disengagement and re-traumatisation.

This research hopes to provide a synthesis of evidence for urgent prioritisation of the incorporation of TIP principles into psychotherapeutic interventions aimed at survivors of CSA in Ireland. Using desk-based research methods, it will review recent national and international research, government reports, and policy documents to explore:

- What is known about the nature and scale of CSA in Ireland and what are its effects on adult survivors?
- Is there a convincing rationale for the incorporation of TIP approaches to psychotherapeutic services made available to this group?
- What might the effective incorporation of TIP principles into psychotherapeutic services aimed at this group look like?

A description of the working definitions of key concepts used in this work, including psychological trauma, Trauma Informed Practice, and Child Sexual Abuse can be found in Appendix A.

Methodology

The dissertation adopted a desk-based research approach, systematically reviewing and synthesising relevant literature from the last 15 years. This was necessary because research

on CSA seemed to suffer “episodic amnesia”, where lines of inquiry are “taken up and abruptly abandoned, only to be rediscovered much later” (Herman, 2022 p. 9). The review was predicated on searches across three sources, the DBS library databases, the library database of another Irish university, and Google Scholar. These gave proprietorial access to databases such as EBSCO Health Databases, PubMed, PsycINFO, JSTOR. MEDLINE (via EBSCO) and a broad range of up-to-date peer-reviewed journals, books, reports and other grey material. Search parameters included: Child Sexual Abuse, CSA, child abuse, childhood trauma, complex trauma, trauma-informed practice/care, psychotherapy, psychotherapeutic interventions, effects, responses, treatment, therapy, adults. The 10-questioin CASP framework (Long et al. 2020, see Appendix B) was used to evaluate the reliability and methodological rigor of sources.

Ethical Considerations

Even though desk-based research involves no direct engagement with survivors of CSA (a highly vulnerable group), their advocates, or those working with them, care was taken to faithfully represent their views, stories, experiences, and perspectives, as these occurred within the extant literature. Representation of the voice of this group underpinned the selection, critical analysis and synthesis of material reviewed. Privilege was given to survivor-informed articles, books, grey material, and websites. Again, the CASP framework (Long et al., 2020) was used to ensure chosen sources conformed to the high ethical standards.

Literature Review

Experiences of Child Sexual Abuse

Judith Herman (2022) asserts that unlike its adult counterpart (which erodes the structure of an already-formed personality), repeated *childhood* trauma *forms* and *deforms* the personality of the child, evoking "abnormal states of consciousness in which the ordinary relations of body and mind, reality and imagination, knowledge and memory, no longer hold" (Herman, 2022 p. 140). For her, its physical nature, frequency, duration, and secrecy; the intense sense of betrayal, abandonment and isolation it involves; and the profound loss of agency, stigma and boundary violations that accompanies it, add layers of complexity to CSA that supersede other forms of trauma (Herman 2022). They result in a highly "complex psychopathology" that includes "deformations in conscious, individuation, and identity" (Herman 2022 p. 157).

To survive CSA, children adapt in three adaptive strategies: they mobilise dissociative defences, engender fragmented identities, and develop pathological ways of regulating emotions (Herman, 2022). But these adaptations come at the cost of "a prodigious array" of relational, psychological, and physical symptoms that "speak in a disguised language of secrets too terrible for words" (Herman, 2022 p. 140).

To *avoid* abuse, children "develop extraordinary abilities to scan for warning signs of attack", often remaining in constant states of "autonomic hypervigilance" that are highly attuned to (often unconsciously) the inner states of others (Herman, 2022 p. 146). When avoidance fails, *compliance* kicks in, especially automatic obedience, a type of defence that reinforce feelings of helplessness, appeasement, and futility of resistance. "Jealous surveillance" and "capricious enforcement of rules" by abusers often reinforce these feelings and disempower

victims further (Herman, 2022 p. 146). The imperative of keeping up the appearance of normality, causes their social lives to become "profoundly limited" and cloaked in secrecy (Herman, 2022 p. 146). Feelings of abandonment, which can be "resented more keenly than the abuse itself" (Herman 2022 p. 147), often result in rage towards figures other than the perpetrator.

Within this climate of disrupted relationships, the child must find a way to preserve primary attachments to caregivers, even when they are abusive. They must also develop a sense of *self* in relation to these people. Finally, they must develop a capacity for "bodily self-soothing in an environment without solace" (Herman, 2022 p. 148). To do this, they tend to minimise/rationalise/excuse the abuse to which they have been subjected, absolve abusers and their enablers of all blame, and even expunge abusive experiences entirely from their conscious memory (Herman, 2022). This involves the use of defences such as denial, suppression, and disassociation, which, under extreme conditions, can result in 'splitting'. In many cases, disassociation becomes not merely an ego defence but a "fundamental principle of personal organisation" (Herman, 2022 p. 149).

To coexist with the abuse, the child must construct a system of meaning that justifies it. Almost inevitably, this results in construction of their own 'badness', which they cling to tenaciously to preserve some semblance of power over their unbearable circumstances and avoid slipping into existential despair (Herman 2022). This can become a core principle around which their subsequent identity is formed. Their debased self-view can become "camouflaged" in attempts at *goodness*, profound empathy, social conformity, high performance, and perfectionism (Herman 2022 p. 154). Ironically, these tend to reinforce the belief that their true selves, if revealed, would be shunned. As a result, they fail to integrate

their debased and exalted selves, which can also affect their personality organisation going forward.

Similar failures of integration happen in the CSA survivors' representation of others (Herman, 2022). In intrafamilial CSA, attempts at preserving primary attachments can cause children to develop idealised images of their abuser (or aspects of them). Since these cannot be integrated with perpetrator's abusive elements, survivors are unable to form coherent representations of safe caregivers. Such representations are often evoked in stressful times (especially by children) to sooth overwhelming emotions. Failure to develop such representations can disrupt individuals' capacity for emotional regulation and leave them vulnerable to external sources of solace and validation, indiscriminate attachment to others, and tenacious clinging on to relationships, even when these are manifestly harmful.

Finally, CSA can lead difficulties with regulation of autonomic and emotional states, and individualised symptoms associated with the incorporation of CSA trauma (van der Kolk, 2014; Lavine, 2015; Dana, 2018; Herman, 2022). Cook et al. (2005 p. 3) provide a useful graphic that summarises domains of possible impairment caused by exposure to complex trauma, such as CSA, (see Appendix C).

Given that the severity of CSA is linked to age of onset and duration (Sneddon, 2016) it is useful to look at these factors in the Irish context. Carr et al. (2009) found that a significant minority of survivors experienced severe *institutional* CSA abuse very frequently, with 14.2% reporting it occurred 11-100 times and 9.72% reporting more than 100 instances. The average age of initiation was 10.73 years, and the average duration was 2.83 years. For severe *intrafamilial* CSA, 4 of the 14 survivors in this category reported that it had occurred 11-100 times, with an additional 4 saying it exceeded 100 times. The average age of initiation was much younger in families (8.55 years) and the average duration was longer (4.48 years).

While the quantum of figures varies from study to study, they are replicated closely in other studies (Fisher, 2017; Sneddon et al, 2016; Maniglio, 2015).

In terms of the instance of CSA, figures report that child protection and welfare referrals to *Tusla* rose by 5% between 2020 and 2021, while referrals child sexual abuse referrals increased by 19% in the same timeframe, from 3,653 to 4,331 (O'Mahony, 2021). The Special Rapporteur on Child Protection in Ireland characterised this as a significant "cause for concern" (O'Mahony, 2022 p. 40). Similarly, McGlynn (2021) reported that the number of CSA victims on the Children at Risk in Ireland (CARI) waiting lists in more than doubled between 2020 and 2021 (from 92 to 198). Clearly, this issue with figure in psychotherapeutic encounters for some time.

Overall, there is good evidenced that a significant minority of children were (and continue to be) subjected to on-going, frequent and prolonged patterns of sexual abuse, and that this results in complex trauma characterised by deformations of consciousness, individuation and identity, the effects of which are associated with significant psychological disorders, trauma symptoms, and insecure attachment.

The Sexually Abused Child, Turned Adult

In terms of empirical evidence for the persistence of these effects into adulthood, it is instructive to begin with Carr et al.'s (2009) study. While this is not the most current one, was the largest and most definitive of its kind when it conducted, it was focused exclusive on Ireland, and its figures have been corroborated by subsequent studies. It found that 81.7% of participants had historic or currently diagnoses of anxiety disorder (current: 44.9%, lifetime: 34.4%); mood disorder (current: 26.7%, lifetime: 36.0%); substance use disorder (current: 4.9%, lifetime: 35.2%); and personality disorders (30.4%). The three most common *anxiety*

disorders were social phobia (current: 19.8%, lifetime: 10.9%); generalised anxiety disorder (current: 17%, lifetime: 6.9%); and post-traumatic stress disorder (current: 16.6%, lifetime: 8.5%). Depression was most common *mood* disorder (current 26.7%, lifetime 36.0%), followed by dysthymia (current only 11.3%). In terms of *personality* disorders, 21% of those surveyed had diagnoses of avoidant personality disorder; 6.9% antisocial personality disorder; and 5.7% borderline personality disorder.

A range of *trauma* effects was also evident, with 59.9% of participants showing avoidance of reminders of early trauma, flashbacks, impaired self-reference, depression, anxious arousal, and maladaptive tension reduction (Carr et al., 2009). They also found an impact on adult attachment styles, with 83.4% of CSA survivors displaying insecure attachment, of which 44.1% were fearful, 26.7% dismissive and 12.6% preoccupied. Other clinically significant symptoms included anger (32%), sexual concerns (23.9%), and sexual dysfunction (12.6%).

A wide range of similar literature has corroborated Carr et al.'s (2009) findings (Wolfe, Francis, and Straatman, 2006; Ford & Courtois, 2020; Trask et al. 2011; Courtois & Ford, 2016; Finkelhor et al., 2014; van der Kolk, 2014; Herman, 2022). Wolfe, Francis, and Straatman (2006) found that 88% of adult survivors of CSA had been diagnosed with a DSM-listed disorder (American Psychiatric Association, 1994) during their lifetime, with PDST and alcohol, and mood disorders most commonly reported. Trask et al. (2011), found that 37-53% of adults had PTSD and traumatic reactions, including re-experiencing and active avoidance of abuse reminders. A similar amount had externalizing behaviours and 43-67% demonstrated internalising disorders. 55% of cases reviewed showed co-occurrence of two or more disorders.

Other studies conflicted with Carr et al. (2009). For example, Hailles et al. (2019) tested correlations between CSA and 28 different long-term harmful outcomes. They found only

weak or moderate correlations between CSA and some conditions identified by the Carr et al. as significant. The strongest psychiatric associations measured were with conversion disorder, borderline personality disorder, anxiety and depression.

Finally, it has been suggested that certain outcomes only emerge during adulthood, including some types of physical health conditions, problems with sexual intimacy, interpersonal relationship issues, and employment difficulties. Becoming a parent can also be a trigger for both female and male victims and survivors (Montgomery, 2013; Nelson, 2009). Fisher, et al. (2017) found that 10% of their study sample reported becoming pregnant as a result of CSA. Other effects, like mental health conditions, PTSD, anxiety and increased vulnerability to sexual re-victimisation cut across life stages (Fisher et al., 2017).

Overall, there is good evidenced that a range of common symptoms of CSA carry through to adulthood, including PTSD, anxiety, depression, dissociation, emotional dysregulation, interpersonal difficulties, re-victimisation, physical symptoms, and substance use disorder. While Hailles et al. (2019 p. 835) concluded that much work still needs to be done to "understand the mechanisms underlying the association" between CSA and various long-term disorders, the picture outlined above seems well accepted by practitioners, national and international agencies and websites (see, for example, HSE, 2024; *Tusla*, 2025; Very Well Mind, 2023).

Discussion

Trauma Informed Practices within Psychotherapeutic Responses to Survivors of CSA in Ireland.

The picture painted above of the physiological, psychological and relationship issues faced by adult survivors of CSA poses "some of the most difficult challenges and dilemmas" that

can be presented to psychotherapists (Courtois & Ford, 2016 p. 3). In fact, it is difficult to see these could be addressed effectively outside of a TIP-informed framework (SAMHSA, 2014). Evidence has emerged that survivors report higher levels of satisfaction, greater engagement, and improved feelings of well-being where TIP principles are deployed (Knight, 2019; Isobel & Edwards, 2017). This may be why, internationally, TIP-informed services have been recognised as a gold standard in psychotherapeutic responses to such clients (Levenson, 2017; Bloom & Farragher, 2013; Fallot & Harris, 2017).

In Ireland, the historical context of institutional abuse has shaped public and professional responses to CSA survivors (McElvaney, 2019). It is encouraging to see a growing incorporation of TIP principles into mental health services (McElvaney, 2019) and education (Hickey et. al. 2020), there appears to be considerable variability in the fidelity within which this is applied, including in psychotherapeutic settings (McElvaney, 2019). The scoping report (GoI, 2024) that led to the statutory commission of inquiry into the sexual abuse of children in Irish schools, and the subsequent Ryan Report (GoI, 2010) prompted renewed interest and commitments to improve therapeutic services. Indeed, some resultant action is evident, for example, in service framework and trauma-informed training courses developed by One in Four (One in Four, 2022; 2024).

Yet, CSA survivors and their advocacy groups, are still calling for greater access to trauma-informed services that specialise in sexual violence (RCNI, 2022). They assert that traditional service models of support, with their emphasis on treating symptoms, are inappropriate. They advocate for trauma-informed services that are empowering, healing-based, non-directive, non-judgemental, and survivor-led (RCNI, 2022). Unavailability and inappropriateness of services notwithstanding, they also point to a range of systemic factors that leave them unprovided for, including access issues, funding constraints, long waiting lists, limited TIP

training for practitioners (Mental Health Reform Ireland, 2020; McElvaney, 2019), and "inappropriate diagnosis or under detection of trauma-related symptoms" (Hegel in Cook et al., 2017 p. 111). This has caused some adult CSA survivors (e.g. Crockett, 2021, unpaginated) to assert that lack of incorporation of TIP principles, means that many CSA survivors forego "much needed treatment because the risk of re-traumatisation by a provider is too high".

The Affordances of Trauma Informed Practice within Psychotherapy for Adult Survivors of CSA

As previously noted, Trauma Informed Practice (TIP) is an approach to health and care interventions that is grounded in a comprehensive understanding of the impact of trauma on neurological, biological, psychological and social development. It takes the view that "any person seeking services or support might be a trauma survivor" (Goodman et al. in Knight, 2019 p. 81). TIP emphasises compassion and individualised care within empathetic and trusting relationships and focuses on creating healing environments that prioritise safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice and choice; and, cultural, historical, and gender sensitivity (SAMHSA, 2014). It aims to foster resilience by validating the survivor's experiences, promoting self-efficacy, and shifting the clinical perspective from "What is wrong with you?" to "What has happened to you?" (van der Kolk, 2014). A central goal is to allow survivors to feel seen and heard, without shame. Finally, it takes a proactive interest in the wellbeing of those who advocate and work with survivors of complex trauma (Crivatu, et al., 2023; Willcott-Benoit & Cummings, 2024).

Several therapeutic modalities have been shown to be effective in working to ameliorate psychological effects of CSA in adult survivors. They include prolonged exposure therapy,

trauma focused cognitive-behavioural therapy, cognitive processing therapy, psychodynamic therapy (though traditional versions of these may require adaptation to fully incorporate the survivor's lived experience of trauma), dialectical behaviour therapy, eye movement desensitisation and reprocessing (EMDR), dialectical behaviour therapy, and psychoeducation, especially around the psychological and somatic effects of PDST, dissociation, and hypervigilance (Shapiro, 2017; Levine, 2015; Ford & Courtois, 2020). Mindfulness, attachment-based interventions and narrative therapy (focused on resilience and recovery) have also been used to good effect (Ford & Courtois, 2020). It is believed that all these approaches can benefit greatly from the incorporation of TIP principles (SAMHSA, 2014).

In their meta-analytical study, Trask et al. (2011), evaluated the effectiveness of therapeutic interventions and tried to identify participant and treatment characteristics that moderated this. They found that available treatments *were* successful in reducing trauma, externalising behaviours, and internalising problems. The also found that longer interventions, those focussed on older clients, and programmes involving a greater proportion of males, had better treatment outcomes (Trask, et al., 2011). Finally, the found that that group and individual treatments were “equally effective” in treating complex trauma (Trask, et al., 2011 p. 13); a finding replicated by Yun & Fiorini (2020), who looked at a variety of settings including psychotherapy and counselling ones.

Increasing knowledge and awareness of the neurobiological impact of trauma, such as persistent and unhelpful changes in stress responses, dysregulation in autonomic systems and emotions, problems with memory processing, and “somatosensory intrusions” characteristic of unresolved trauma (Ogden et al, 2006 p. xxix) often seen in adult survivors of CSA have led to the development of approaches such as Somatic Experiencing (Levine and Frederick,

1997; Levine, 2008; Levine, 2010; Payne, Levine, and Crane-Godreau, 2015), Somatic Trauma Therapy (Rothschild, 2000), and Sensorimotor Psychotherapy (Ogden et al, 2006; Ogden and Fisher, 2015). These use embodied experiences of trauma as their primary entry point for intervention and seek to understand how the client's body processes information in ways that influence emotional expression and meaning making. These approaches are often used to increase the "depth and efficacy" of traditional talk-based modalities (Ogden, et al., 2006 p. xxviii). In fact, their amenability to incorporation into other therapeutic modalities seems to have been central to their widespread adoption.

Courtois and Ford (2016 p. 9), assert that, when working with sufferers of complex trauma, it is not the therapeutic modality that determines effectiveness, but the development of "a positive therapeutic relationship, a caring empathetic psychotherapist, and attention to the ebb and flow of the therapy session, including therapist attunement and connection, transference and countertransference, boundary negotiation, and attachment-level response". Like Levinson (2017), they emphasise that such work is primarily about the creation of safe, caring and supportive therapeutic environments and relationships in which the therapist demonstrates core integrative competencies (congruence, empathy, compassion and positive regard) and titrate exposure to historical material during therapy, in line with the client's ability to stay present and their levels of distress.

For Courtois & Ford, 2016, the ultimate aim is to ensure positive therapeutic encounters that validate clients' feelings, avoid the risk of re-traumatisation, allow engagement with harmful beliefs, and develop individuals' resilience and agency. As Levinson (2017, pp 106-107) puts it, they see presenting problems as indicators of maladaptive coping responses to trauma and "interrelated emotional wounds". Thus they "work on building healthy skills rather than simply addressing symptoms" and supporting the client's need "to connect with others, to be

respected, and to become hopeful regarding their own recovery" (Levinson, 2017 p. 106). All of these writers offer a blueprint for how TIP principles can be translated into psychotherapy with adult survivors of CSA; a blueprint that is highly congruent with somatic and sensory approaches. Cook et al. (2005 p. 6) identified six elements of effective trauma-informed interventions, namely safety, self-regulation, self-reflective information processing, traumatic experiences integration, relational engagement, and positive affect enhancement. Appendix C. outlines these in a little more detail.

Deploying TIP Principles within and around the Psychotherapeutic Encounter.

Sheridan and Carr (2020 p. 9) found that survivorship of CSA "involves a complex adaptation to post-traumatic environments" involving "interwoven aspects of positive behavioural changes, perceptions of growth and continued distress". Encouragingly, they also reported a "burgeoning literature" to support the value of TIP-informed supports in promoting a post-traumatic growth among CSA survivors. Post-traumatic growth refers to "positive changes in one's life domains … due to cognitive processing and emotional engagement after a traumatic event" (Tedeschi and Calhoun in Willcott-Benoit & Cummings, 2024 p. 3644). Sheridan and Carr (2020 p. 9) found that post-traumatic growth was linked to most saliently to the development of a positive post-trauma identity, which was associated with "increased self-acceptance and self-efficacy".

When a post-trauma identity was positive and positively affirmed, survivors used this to "derive salutary meaning from their abuse experiences" (Sheridan and Carr, 2020 p. 9). They engaged in "positive reappraisal strategies, acceptance of trauma, and cognitive efforts to process the abuse" and challenge "their trauma-laden belief systems" in ways that allowed the introduction of new information into their

survivorship narratives (Sheridan and Carr, 2020 p. 10). When survivors' identities were rejected or disavowed, survivors view themselves as "agents of immoral action" and become less amenable to therapy (Sheridan and Carr, 2020 p. 9).

Trauma informed environments provide safe places to engage in this reappraisal, acceptance, processing, challenging and integration. They do so by maintaining emphasis on relational, physiological, and physical safety, in the hope that these can soothes "physiological arousal to create more positive associations toward moving forward in treatment for both survivors and providers" (Barnes and Andrews, 2019, p. 605).

Relational safety

We have seen how the *trauma* experienced during CSA can lead to a profound sense of insecurity and fearful, dismissive, or preoccupied attachment styles (Carr et al. 2009). We have also seen how it can lead to dysfunctional social interaction patterns, distorted cognitive schema, boundary violations, and emotional dysregulation, which persist into adulthood (van der Kolk 2014). If trauma is at the heart of adult experiences of CSA, then it must be at the heart of healing. TIP comprises an articulation of this approach. It looks for trauma symptoms and sees these as rational (at the time), learned maladaptive coping responses the ensured survival (Levinson, 2017). It seeks to address these within a holistic therapeutic process that foregrounds the therapeutic relationship and environment.

Since CSA occurs within webs of interpersonal relationships, healing the complex trauma invoked by this, must also happen within these (Barnes & Andrews, 2019). TIP approaches provide survivors with experiences of a stable and soothing environment

and a healthy, respectful, trusting, empathetic and supportive client-therapist relationship within which a positive post-traumatic growth mindset can develop. Its aim is to build up resilience, hope, and a set of intrapersonal and inter-personal skills that help develop and sustain post-traumatic growth (Levinson, 2017; Willcott-Benoit & Cummings, 2024).

TIP also acknowledges that CSA can translate into feelings of helplessness, loss of agency, deference to the wishes of others, and the futility of resistance. This can leave the adult survivor feeling comfortable only in relationships over which they can exercise some degree of control. They fare poorly within the kinds of hierarchical support models, such as those that that pertain in medicalised treatment options. Moreover, they can have a propensity for social acquiescence to the point of automatic obedience, which leaves the vulnerable to suggestion and compliance, even when this is not in line with their wishes (Herman, 2022).

TIP informed therapy encourages therapist and client to forsake “the traditional service relationship that replicates some of the most damaging dynamics of childhood trauma” and “accept an unequal relationship in order to avoid worse treatment” (Harris and Fallot in Barnes & Andrews, 2019 p.). These non-hierarchical healing relationships can be a central resource by which therapists can “accompany survivors into their horrific memories of childhood sexual abuse time and again without pulling back to save themselves from the pain of hearing” these (Crockett, 2012 unpaginated). They allow the therapist to remain vigilant to signs of maladaptive coping mechanisms including dissociative defences, fragmented identities, and pathological ways of regulating emotional and autonomic systems (van der Kolk 2014; Lavine, 2017; Herman, 2022), as well as sensitivities to disempowerment and capricious surveillance

(Herman, 2022). Finally, they are vital to maintaining the core conditions of integrative psychotherapy, allowing the therapist to remain available to the client, while modelling adherence to healthy boundaries.

Psychological Safety

Safe client-therapist relationships are essentially ones that are consistent, predictable, and non-shaming (Elliott et al., 2020). Within these, clients can be presented with opportunities to integrate idealised abusive fragments of themselves, their (abusive or negligent) caregivers, and others (Henman, 2022). This relationship can also form the basis of dyadic work in with both parties work together through the client's experiences of betrayal, abandonment, isolation, manipulation, guilt, shame, secrecy, stigma, and their sense of personal "badness", in the knowledge that the therapist will be there through thick and thin, and for the long haul. In this way, it is hoped that the client may, in time, develop and internalise more integrated representations of caregivers, which will allow them to regulate anxiety-inducing emotions, decrease their reliance on external sources of solace/validation, and reduce indiscriminate or harmful attachment to others. Finally, this relationship may be used within cognitive-behavioural approaches, to deal with clients' misplaced propensities to minimise, rationalise, and excuse the abuse, and absolve abusers and enablers of blame.

Physical safety

CSA survivors receive enduring physical injury (external and internal) during their abuse, including the contraction of venereal disease (Fisher, et al 2017). The can also exhibit psychosomatic symptoms such as chronic pain, digestive issues, sleep disturbances, fatigue, immune system issues, muscle tension, sensory overload and integration, increased blood

pressure, neurological issues, musculoskeletal problems, respiratory problems, urological problems, and substance use disorders (van der Kolk, 2014). TIP-informed therapists need to remain attentive to these things.

As we saw earlier, survivors can be hypervigilant around safety, often on a near constant basis, while remaining totally unaware of what triggers this. Additionally, they can enter quickly into various levels of disassociation without awareness of precipitating stimuli. The Polyvagal Theory proposes that various branches of the Vagus nerve work together to monitor visceral feedback and environmental stimuli, "including the voices and faces of the people around us" (Van der Kolk, 2014 p. 47), and respond to risk and safety based on this (Porges, 2009; Van der Kolk, 2014; Dana, 2018;). Porges (2009 p. 4) calls this capacity "neuroception". Van der Kolk (2014 p. 47) believes that this theory explains why feelings of "attunement", being listened to, and experiencing safety are so important in allowing psychotherapeutic clients transition from fearful to more regulated autonomic states.

The physical built environment is also important in TIP (Levine, 2015). Clients who are vulnerable to dissociative states, can find large buildings, waiting areas, and therapy spaces difficult to navigate at times (Crockett, 2021). This can sometimes trigger confusion and even dissociation. Warm, comfortable waiting and therapeutic spaces can be welcoming and soothing for anxious clients. If possible, they should be free of large crowds and loud noises. A smiling receptionist can also offer calmness and reassurance. Nor should these spaces be claustrophobic or confining. Furniture should not put the client in an uncomfortable or difficult positions. Even minor touching should be avoided, without extensive negotiation, explanation, and preparation for this. Even then, this must be done anticipating the inability of many survivors of CSA to say "no" (Crockett, 2021). Directing clients to sit or lie down in a place where they

cannot see who might enter the space can be triggering. Areas should be free from potential hazards that might trigger anxiety, e.g. poor lighting, clutter, and absence of visible exits points or rest and disability accommodations. Finally, physical reminders may need to accompany oral information or points they should think about (Crockett, 2021).

Challenges to the Application of TIP within Trauma Therapy

Variability in the fidelity with which TIP is deployed in psychotherapeutic settings at home (McElvaney, 2019) and abroad (Knight, 2015) have already been noted. This may be because their implementation can involve significant cultural change for service providers (Bloom and Farragher, 2013). Other barriers to the adoption of TIP include the legal issues involved, the stigma that still operates around CSA (Knight, 2015; van der Kolk, 2014), the lack of specialised training for therapists (Cook et al., 2017; Isobel & Edwards, 2017) and the consistent failure of relevant services to detect and properly diagnose trauma-related symptoms (Cook et al., 2017).

The difficulty of working with adult survivors of CSA may also comprise a barrier to adequate staffing of services. Crivatu et al. (2023) found evidence of significant negative vicarious impacts on those working with survivors of sexual violence including *trauma symptoms (included* avoidance of intrusive thoughts, nightmares, flashbacks and persistent visual imagery off clients' abuse); *diminished perceptions* of safety (around self, family and clients) and trust (in care and justice systems); and *psychological distress* (including isolation, depression, anxiety, irritability sadness, anger, and compassion fatigue). Those with a "history of trauma" seem particularly vulnerable to its vicarious effects (Cook et al, 2017 p. 112). Knowledge of these issues is undoubted at the heart of SAMHSA's (2014 p. 13) assertion that deployment of TIP approaches must involve supporting staff who are "experiencing significant secondary traumatic stress or vicarious trauma". Clinicians

themselves echo these concerns, reporting that, to work in trauma-informed ways, they required service providers to clarify the concept of TIP, address issues of staff well-being, support different ways of working, and change workplace cultures, where necessary (Willcott-Benoit & Cummings, 2024). Crivatu et al. (2023) remind those involved of the need to maintain regular supervision, establish clear professional boundaries, and practice self-care.

The challenging, intensive, and time-consuming nature of TIP orientated services for adult CSA survivors, has resourcing implications also (Willcott-Benoit & Cummings, 2024). This is partly due to the number of people affect by historical sexual abuse, for whom post-trauma growth will comprise "a protracted process" (Sheridan and Carr, 2020 p.10), involving "positive behavioural change, perceptions of growth and continued distress" (Sheridan and Carr, 2020 p. 9). It is also because, as has already been shown, the issue of CSA is not abating.

Finally, while Wilson et al. (2020) found a high level of interest among mental health professionals in TIP-informed approaches, they suggested that the dominance of the (hegemonic) medical model paradigm within the field is "insidiously" perpetuates "a custodial approach and loss of psychotherapeutic and interpersonal skills" (Wilson et al., 2020 p. 912). They assert that this ideology is unlikely to lose its potency any time soon.

Conclusion

Using a desk-based research strategy, this study sought to outline of the scale and nature of CSA in Ireland and explore understandings of its psychological and physiological effects on adult survivors. It also sought to review and evaluate the incorporation of TIP into psychotherapeutic responses aimed at supporting this group. Finally, it sought to provide

practical guidance for clients, psychotherapists, service providers, and policy makers on how TIP principles might be integrated into the psychotherapeutic encounter effectively. Overall, the review strongly supported the value of incorporating TIP approaches into a range of psychotherapeutic modalities and offered examples of how this might be done to improve patient engagement, treatment adherence, and healing outcomes. It also noted how TIP can address issues of vicarious trauma and wellbeing amongst those working with adult survivors of CSA.

Future research might usefully look at gathering empirical evidence on whether, and if so, the degree to which, TIP is currently being incorporated into psychotherapeutic supports for adult survivors of CSA in Ireland. This could be done across different settings and modalities. A similar exercise could be completed in relation to other types of complex trauma. Particular emphasis might be placed on whether it is deployed within individual or group therapies.

The research strategy used in this work was neither sophisticated nor unique. It was limited by its desk-based approach and the scope and nature of the assignment for which it was prepared. Yet, it proved to be a highly effective way to investigate the topography of the field and to identify and discuss pertinent issues within this. It is hoped that the review offers enough information and discussion to be of interest to stakeholders, especially if it becomes the basis of a disseminated article or investigative work. Whatever interest it generates from others, preparation of this assignment comprised highly instructive and timely experience for the author, who used it to deepen his interest in, and inform himself of, salient issues surrounding the provision of TIP-informed psychotherapy to adult survivors of CSA. If recent figures set out in this work continue to hold, it is highly likely that he will encounter such clients in his therapeutic work in the near future.

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Appendix A

Definitions

Psychological trauma is conceptualised within this work as "the unique individual experience of an event or enduring conditions, in which: 1. The individual's ability to integrate his/her emotional experience is overwhelmed, or 2. The individual experiences (subjectively) a threat to life, bodily integrity, or sanity" (Pearlman & Saakvitne, 1995, p. 60). As well as having profound psychological effects, trauma can become deeply embodied, influencing physiological responses, behaviours, and emotions. Within psychotherapy, it can impair an individual's ability to remain conscious to what is happening, integrate their feelings, and make sense of these.

Trauma Informed Practice (TIP) is "not a manualised intervention" (Barnes & Andrews, 2019) but an approach to health and care interventions that is grounded in understandings of the impact exposure to trauma can have on an individual's neurological, biological, psychological and social development. It encourages the creation of environments in which survivors feel heard, respected, and validated (Elliott et al., 2020). SAMHSA (2014) identifies six key principles of trauma informed care, namely safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice and choice; and cultural, historical, gender sensitivity. Levinson (2017) provides a useful and accessible description of each of these principles that is recommended to the reader. It is asserted that these principles should be placed at the heart of responses to CSA (Knight, 2015; Courtois & Ford, 2016). While the terms Trauma Informed Practice (TIP) and Trauma Informed Care (TIC) are often used interchangeably, "practice is more accurately applied to clinical intervention, while care refers to the organizational [sic] context within which services are provided" (Knight, 2019).

Child Sexual Abuse (CSA), is thought to occur "when a child is used by another for his or her gratification or arousal, or for that of others". (Tusla, unpaginated). It includes "wilful exposure of the child to pornography" and "wilful sexual activity in the presence of the child" (Government of Ireland (GoI), 2015 p. 6). Schedule 2 of the Children First Act (GoI, 2015) specifies that psychotherapists and counsellors registered with a voluntary professional body are "Mandated Persons" who must report instances of CSA to *Tusla*, the national child and family agency in Ireland.

Appendix B

The 10 questions of the CASP qualitative checklist tool (Long et al., 2020 p. 33).

1. Was there a clear statement of the aims of the research?

2. Is a qualitative methodology appropriate?

3. Was the research design appropriate to address the aims of the research?

4. Was the recruitment strategy appropriate to the aims of the research?

5. Was the data collected in a way that addressed the research issue?

6. Has the relationship between researcher and participants been adequately considered?

7. Have ethical issues been taken into consideration?

8. Was the data analysis sufficiently rigorous?

9. Is there a clear statement of findings?

10. How valuable is the research?

Appendix C

SIDEBAR 1.

Domains of Impairment in Children Exposed to Complex Trauma

I. Attachment

Problems with boundaries
Distrust and suspiciousness
Social isolation
Interpersonal difficulties
Difficulty attuning to other people's emotional states
Difficulty with perspective taking

II. Biology

Sensorimotor developmental problems
Analgesia
Problems with coordination, balance, body tone
Somatization
Increased medical problems across a wide span (e.g.)
Pelvic pain, Asthma, Skin Problems,
Autoimmune disorders, Pseudoseizures

III. Affect regulation

Difficulty with emotional self-regulation
Difficulty labeling and expressing feelings
Problems knowing and describing internal states
Difficulty communicating wishes and needs

IV. Dissociation

Distinct alterations in states of consciousness
Amnesia
Depersonalization and derealization
Two or more distinct states of consciousness Impaired memory for state-based events

V. Behavioral control

Poor modulation of impulses
Self-destructive behavior
Aggression toward others
Pathological self-soothing behaviors
Sleep disturbances
Eating disorders
Substance abuse
Excessive compliance
Oppositional behavior
Difficulty understanding and complying with rules
Reenactment of trauma in behavior or play (sexual, aggressive, etc.)

VI. Cognition

Difficulties in attention regulation and executive functioning
Lack of sustained curiosity
Problems with processing novel information
Problems focusing on and completing tasks
Problems with object constancy
Difficulty planning and anticipating
Problems understanding responsibility
Learning difficulties
Problems with language development
Problems with orientation in time and space

VII, Self-concept

Lack of a continuous, predictable sense of self
Poor sense of separateness
Disturbances of body image
Low self-esteem
Shame and guilt

Appendix D

SIDEBAR 2.

Six Core Components of Complex Trauma Intervention

1. **Safety:** The installation and enhancement of internal and environmental safety.
2. **Self-regulation:** The capacity to modulate arousal and restore equilibrium following dysregulation across domains of affect, behavior, physiology, cognition (including redirection of dissociative states of consciousness), interpersonal relatedness and self-attributions.
3. **Self-reflective information processing:** The ability to effectively engage attentional processes and executive functioning in the service of construction of self-narratives, reflection on past and present experience, anticipation and planning, and decision making.
4. **Traumatic experiences integration:** The transformation, incorporation or resolution of traumatic memories, reminders and associated psychiatric sequelae into a nondebilitating, productive and fulfilling existence through such therapeutic strategies as meaning-making, traumatic memory containment or processing, remembrance and mourning of the traumatic loss, symptom management and development of coping skills, and cultivation of present-oriented thinking and behavior.
5. **Relational engagement:** The repair, restoration or creation of effective working models of attachment, and the application of these models to current interpersonal relationships, including the therapeutic alliance, with emphasis on development of such critical interpersonal skills as assertiveness, cooperation, perspective-taking, boundaries and limit-setting, reciprocity, social empathy, and the capacity for physical and emotional intimacy.
6. **Positive affect enhancement:** The enhancement of self-worth, esteem and positive self-appraisal through the cultivation of personal creativity, imagination, future orientation, achievement, competence, mastery-seeking, community-building and the capacity to experience pleasure.