Thesis submitted in partial fulfilment of the degree of Doctor of Clinical Psychology (DClinPsych)



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Amendments

SRL

1. Amend definition of autism to be more neuro-affirmative and less deficit based

'Autism is conceptualised here as a naturally occurring variation in human neurodevelopment, impacting people's cognitive style, the way they communicate with others, and the way they experience sensory input (Milton, 2012; Swanepoel, 2024). This definition positions autism as a lifelong characteristic, rather than a disease that requires curing. It is associated with unique strengths and skills, but also challenges and difficulties, which can often be located in the inaccessibility of the neurotypical world, rather than within the individual themselves, as per a social disability model (Oliver, 1981, as cited in Lawson & Beckett, 2021; Sasson et al., 2017). Currently, the majority of Western countries diagnose autism based on a medical model, which focuses on criteria of deficit (e.g., International Classification of Diseases, 11th revision [ICD-11]; WHO, 2019). It has been suggested that this continues to perpetuate a discriminatory attitude towards autistic people, which often overlooks lived experience and autistic perspectives (Anderson-Chavarria, 2021). Nonetheless, this system is how many individuals access necessary support and services at present.

Shifting towards a more neuro-affirming approach for autistic people involves using less pathologising language, advocating for a strengths-based approach, improving access to services, centring autistic voices, and promoting autonomy and acceptance (Nicolaidis et al., 2015; Bottema-Beutel et al., 2021; Swanepoel, 2024). To this effect, in this review, an identity-first phrasing will be utilised when referring to autistic people, rather than person-first (e.g., 'person with autism'), as this has been indicated by the autistic community as a more validating and affirming preference (Taboas et al., 2022). As the language around

autism has rapidly developed in recent years, individual studies included may refer to autism differently.' (p.18)

2. Clarify that the studies that are included are based on self-report of self-esteem and so will have included a more able and more verbal autistic population. Include this as a limitation of the SRL

'Every study measured self-esteem as a self-reported construct, meaning that all participants included will have been required to be verbal, and relatively functionally able, particularly related to language comprehension and expression and understanding conceptual ideas. These requirements may not apply to all autistic people, and therefore likely represent a particular subset of the population.' (p.31)

'In addition, as the participants included were verbal and of a level of functional ability to consent to and take part in the research, this will have excluded autistic individuals who are not in this group, and therefore results cannot be considered to be representative of the autistic population as a whole.' (p.38)

TDRP

1. Add a sentence to define self-compassion, include reference to Neff's work and definition.

'Self-compassion refers to this process directed inward, when one is supportive towards the self in response to pain or suffering, whether in response to external challenges, or personal inadequacies, and this is linked to mental and physical well-being (Neff, 2003; Neff, 2022). Neff (2022) postulates that self-compassion requires turning towards the suffering, and being present with this discomfort, and that it should engender feelings of care and warmth, rather than judgement.' (p.87)

2. Clarify what ‘emotional clarity’ means for the purposes of this thesis and whether it is an established construct. Alternatively, change emotional clarity to a different term, perhaps ‘emotional regulation skills’?

‘an element of the Trait Meta-Mood Scale of emotional intelligence (Salovey et al., 1995) that refers to the ability to identify and differentiate what one is feeling, which is necessary for deploying effective emotional regulation strategies and limiting distress’ (p.86)

3. Acknowledge that 98 people started to complete the study, but only 58 completed. Add a comment about this in your discussion

‘95 participants began to participate, however only 57 of those were eligible to be included, based on completing all of the necessary measures.’ (p.118)

‘Furthermore, significantly more participants began to fill out the measures than completed them, despite efforts being made to keep the participant burden as low as feasible. This suggests there may have been more interest in this topic than indicated, but unknown barriers prevented some participants from fully taking part.’ (p.105-106)

4. Add information about how your sample compares with the local or national staff population working in forensic mental health

‘Larger studies in general mental health inpatient environments offer insight into the demographics of staff in these settings, indicating that there are more females (64%) than males (36%) (Johnson et al., 2011). The same study indicated that psychologists made up 2% of staff, and ethnicity was reported as primarily White (75%). Comparable statistics have not been reported specifically for forensic settings, however it would seem that the sample of this study was likely not representative of the workforce overall.’ (p.105)

5. Add basic descriptive statistics on the measures that were completed (range, means, alphas in your sample) and comment on the comparison with norms / cut offs

'Due to the lack of large-scale study data, there are no current established norms or cut offs for the STA, however within the sample overall, relational security was rated similarly to previous literature such as Chester et al., (2017) (M=2.05, range=.93-2.79, α=.93). Compassion satisfaction for the sample fell in the average range, according to norms established by Stamm (2010) for helping professionals (M=37.23, range=16.00-49.00, α=.90), although cut-offs are not encouraged for diagnostic purposes. For burnout, the sample was also average (M=25.05, range=14.00-38.00, α=.84), as was secondary traumatic stress (M=22.53, range=12.00-39.00, α=.87). Self-compassion within the sample was moderate (Neff, 2011) (M=3.04, range=1.58-4.17, α=.89).' (p.94)

6. Remove any description of findings as almost or nearly clinically significant

See page 98.

7. Add some brief clinical implications of the work, both at the individual and system level

'Given the results of this study and the literature that has come before it, it appears that self-compassion-based interventions and approaches may be useful in reducing burnout and increasing compassion satisfaction in forensic inpatient staff. A provision for this would be beneficial for patient care outcomes and cost-effective in the long run, as these variables have been shown to contribute to staff turnover and sickness.

This study suggests that in forensic settings, relational security is associated with more compassion satisfaction and less secondary traumatic stress and may, therefore, be an additionally useful element to address when considering staff's professional quality of life, and their sense of safety and threat in the workplace. It is important to note, however, that wider systemic factors such as the culture, team dynamics, and support offered, are also likely playing a role. These must be addressed also, and the difficulties in this work placed in their context, in order to avoid the problem being located solely within individuals and their sense of personal resilience.' (p.107)

SIP

1. Amend the Phases section title to be called Method

See page 58.

2. Amend the methods section to more clearly describe the methods that were actually followed during the SIP.

See pages 59 and 61.

3. There is very little description of the service context.

'Through an iterative process of discussing relevant issues with key stakeholders in the team, primarily senior staff members, the topic of sexual safety and risk was determined to be of practical relevance and in line with current policy. Initially, there was a query around the difficulty in managing issues related to service users open to the team who posed a forensic risk, but consultation with the wider team indicated that sexual risk as it applies to the population more generally was a concern shared by many disciplines and was appropriate for a SIP.' (p.57)

4. It is not clear how many staff and of what professions/grades were eligible to take part. This raises questions of representativeness and confidence in the confidentiality. At viva we were reassured on the latter. Please add the details given at viva into the text.

'The team consists of 69 staff members in total, 23 of whom are of a nursing background, 13 occupational therapy, and 14 psychology (not including trainee clinical psychologists on placement). These roles are distributed between bands five to eight.' (p.59)

5. Table 2 in fact appears to be two tables. Might the labelling "variable" more appropriately be "participant characteristics" or similar?

See page 60.

6. Amend the methods and results sections to better describe and demonstrate reflexivity in how the themes were derived

'This stance allowed for interpretive coding of the data, not just at the surface-level (i.e., the content), but also a deeper interrogation to ascertain underlying meanings and beliefs. These latent understandings were shaped by the researcher's subjective position and were constructed into themes through critical and active engagement with the data. This process was supported by reflexive journaling and supervision. For instance, the sub-theme 'fighting the good fight', was not a phrase explicitly said by any of the participants, rather it was derived from a sense gained in the process of facilitating the interviews, that staff were often holding the boundary around their service users' sexual rights, while facing opposing views from the others involved (e.g., families, supported living placements, GP's).' (p.63)

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1. Summary of Word Counts

- Systematic Literature Review: 5629 words.
- Service Improvement Project: 5330 words.
- Theoretically Driven Research Project: 5345 words.
- Executive Summary: 547 words.
- Connecting Narrative: 689 words.

2. Abstracts

2.1 Systematic Literature Review: The Relationship Between Autism and Self-Esteem: A Narrative Review of the Literature

Purpose: The aim of this narrative review was to synthesise and assess available research on the relationship between autism and self-esteem in adults, and the factors that are associated with it. **Methods:** A search strategy was developed and after screening abstracts and full papers with an independent second rater, 17 suitable papers were identified. **Results:** Included studies were generally of a cross-sectional design, with one experimental component and five with a between-groups element. All studies recruited autistic participants, whose means of diagnosis varied. Most studies used the Rosenberg Self-Esteem Scale, and self-esteem was found to be poorer in autistic adults when compared to controls. Associated factors included recency of diagnosis, satisfaction with being autistic, autistic pride and identification, stigma, and social support. **Conclusion:** Overall, the studies indicated a significant relationship between self-esteem and other variables related to psychological wellbeing, and studies were of generally good quality. Longitudinal research and experimental designs assessing interventions to improve self-esteem would be a useful next step.

2.2 Service Improvement Project: Exploring Sexual Rights vs. Sexual Safety in a Community Intellectual Disability Service

Background: Concerns around the safety of service users with an intellectual disability has meant that they have been overly restricted, which is not in line with current policy or theory. This paper aimed to establish how a community learning disability team maintain the balance between sexual rights and sexual safety. **Method:** Three main themes were derived from staff interviews using thematic analysis: communication, confidence and competence, and standardised vs individual. **Findings:** Recommendations were made based on staff's sharing of their experiences and identified enablers and barriers. These are shown alongside the response from the service. Implications and limitations are discussed. **Conclusions:** This topic can be anxiety-provoking and staff feel a sense of responsibility. Empowering service users is a strength within the team, but implementing recommendations that improve confidence and competence may be useful.

2.3 Theoretically Driven Research Project: The Impact of Relational Security on Professional Quality of Life for Staff on Forensic Inpatient Units, and the Role of Self-Compassion

Threat in all forms may be considered pervasive for staff working in forensic inpatient units, and there is a lack of research into relational elements of security in these environments. This can have negative consequences for patients, services, and staff, and safety is a primary objective in organisational policy. Burnout, compassion satisfaction, and secondary traumatic stress are components of professional quality of life, and previous literature shows that self-compassion positively impacts these components. The current study was a cross-sectional design, and 57 forensic inpatient staff of various disciplines completed the See Think Act scale (STA), the Self-Compassion Scale Short-Form (SCS-SF), and the Professional Quality

of Life (ProQoL) scale. Results showed that relational security was significantly predictive of compassion satisfaction and secondary traumatic stress, but not burnout. Self-compassion was not found to be a moderator for any of the relationships. This has implications for interventions for staff and indicates directions for future research. The limitations are discussed.

Systematic Literature Review: The Relationship Between Autism and Self-Esteem: A Narrative Review of the Literature

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Second reviewer Charlotte Thomas-Carmichael (Trainee Clinical Psychologist)

Word count: 5629

First submitted May 2025

Supervisors have read and provided feedback on this work and deem it suitable for assessment.

The proposed publication journal for this work is the Journal of Autism and Developmental Disorders. As a leading journal in the field, it focuses on all aspects of autism spectrum disorders and seeks to advance theoretical and applied research. This paper has therefore been formatted according to the journal guidelines (appendix A)

Abstract

Purpose: The aim of this narrative review was to synthesise and assess available research on the relationship between autism and self-esteem in adults, and the factors that are associated with it. **Methods:** A search strategy was developed and after screening abstracts and full papers with an independent second rater, 17 suitable papers were identified. **Results:** Included studies were generally of a cross-sectional design, with one experimental component and five with a between-groups element. All studies recruited autistic participants, whose means of diagnosis varied. Most studies used the Rosenberg Self-Esteem Scale, and self-esteem was found to be poorer in autistic adults when compared to controls. Associated factors included recency of diagnosis, satisfaction with being autistic, autistic pride and identification, stigma, and social support. **Conclusion:** Overall, the studies indicated a significant relationship between self-esteem and other variables related to psychological wellbeing, and studies were of generally good quality. Longitudinal research and experimental designs assessing interventions to improve self-esteem would be a useful next step.

Keywords: *autism; autism spectrum disorder; self-esteem*

Statements and declarations

None to declare.

3.1 Introduction

3.1.1 Autism

Autism is conceptualised here as a naturally occurring variation in human neurodevelopment, impacting people's cognitive style, the way they communicate with others, and the way they experience sensory input (Milton, 2012; Swanepoel, 2024). This definition positions autism as a lifelong characteristic, rather than a disease that requires curing. It is associated with unique strengths and skills, but also challenges and difficulties, which can often be located in the inaccessibility of the neurotypical world, rather than within the individual themselves, as per a social disability model (Oliver, 1981, as cited in Lawson & Beckett, 2021; Sasson et al., 2017). Currently, the majority of Western countries diagnose autism based on a medical model, which focuses on criteria of deficit (e.g., International Classification of Diseases, 11th revision [ICD-11]; WHO, 2019). It has been suggested that this continues to perpetuate a discriminatory attitude towards autistic people, which often overlooks lived experience and autistic perspectives (Anderson-Chavarria, 2021). Nonetheless, this system is how many individuals access necessary support and services at present.

Shifting towards a more neuro-affirming approach for autistic people involves using less pathologising language, advocating for a strengths-based approach, improving access to services, centring autistic voices, and promoting autonomy and acceptance (Nicolaidis et al., 2015; Bottema-Beutel et al., 2021; Swanepoel, 2024). To this effect, in this review, an identity-first phrasing will be utilised when referring to autistic people, rather than person-first (e.g., 'person with autism'), as this has been indicated by the autistic community as a more validating and affirming preference (Taboas et al., 2022). As the language around autism has rapidly developed in recent years, individual studies included may refer to autism differently.

It is estimated that one in 100 people in the United Kingdom are autistic, although this is thought to be an underestimation (National Autistic Society [NAS], 2023), and autistic adults have been found to face challenges in personal, relationship, and occupational domains (Howlin & Magiati, 2017).

Autistic people are more likely to be diagnosed with a common mental health problem than the general population, with one study by Hofvander et al., (2009) establishing a lifetime prevalence rate of 53% for mood disorders, and 50% for an anxiety disorder in autistic adults without an intellectual disability. Evidence also suggests that autistic individuals perceive themselves differently, have lower self-esteem, and have poorer psychological outcomes than those without a diagnosis of autism (Williamson, Craig & Slinger, 2008).

3.1.2 Self-Esteem

Self-esteem is defined as a person's overall evaluation of, and feelings towards, their own self-worth or value as an individual, and this may be positive or negative (Marsh, 1986; Bailey, 2003). Distinct concepts of self-esteem have been researched, including explicit, which is a conscious attitude towards oneself, or implicit, which are unconscious ideas (Stieger & Burger, 2010). A distinction can also be made between global self-esteem, towards an object (i.e., the self) as a whole, or specific, regarding certain parts or elements of that object (Rosenberg et al., 1995). For instance, a person may have relatively high evaluation of their overall worth but have lower self-esteem in relation to specific domains such as physical appearance or academic ability (Orth & Robins, 2023). In addition, self-esteem can encompass feelings towards oneself as an individual, or be collective in nature, reflecting feelings towards a shared group identity such as being autistic (Cooper et al., 2021).

Despite being one of the earliest conceptualised constructs in psychology research, self-esteem and its measurement continue to be contentious due to disagreement as to its actual definition, mechanism, and consequent impact on psychosocial functioning (Tafarodi & Ho, 2006; Donnellan et al., 2011). As such, this review can only make interpretations based on the constructs being measured in the individual studies, which may not represent 'self-esteem' according to all the available literature.

There is much evidence to indicate that self-esteem has a direct impact on mental health, and that lower or more negative self-esteem is a risk factor for various psychopathologies such as depression, anxiety, and aggressive symptomology (Sowislo & Orth, 2013; van Tuijl et al., 2014; van der Cruijsen & Boyer, 2020). A meta-analysis of longitudinal studies found that this relationship is supported by a vulnerability model, in that low self-esteem creates a vulnerability to becoming depressed (Sowislo & Orth, 2013). Associations between self-esteem and criminality, substance abuse, and poorer physical health outcomes have also been found (McCauley et al., 2019).

It would appear, therefore, that being autistic and having low self-esteem are their own risk factors for negative life outcomes and poorer mental health. The relationship between the two may contribute to the overrepresentation of autistic individuals in criminal justice and mental health settings, as well as poorer recognition with regards to physical health (Collins et al., 2023; Sala et al., 2020).

3.1.3 The Context

It is necessary for mental health professionals to have an understanding of the factors that impact autistic people. This is laid out in current UK policy in the Health and Care Act

(Section 181, 2022) which mandates that all staff in health and social care environments are required to have autism awareness training. This is done via The Oliver McGowan Mandatory Training on Learning Disability and Autism, named after Oliver McGowan, who died in care due to a lack of skills and knowledge in providing safe, compassionate, and informed care to autistic people with or without an intellectual disability (National Health Service [NHS] & Health Education England [HEE], 2025).

3.1.4 This Review

Existing evidence indicates that autistic people are at higher risk of developing mental health problems, as are individuals with lower self-esteem. There is some evidence to suggest that autistic people are at risk of developing poorer self-esteem due to issues such as social communication difficulties and stigma (Cooper et al., 2017; McCauley et al., 2019; Nguyen et al., 2020). To our knowledge, no review exploring self-esteem in autistic adults exists which integrates and summarises the available literature.

Synthesising the available research may aid in understanding the relationship between autism and self-esteem and the factors that effect it. This may inform preventative and treatment interventions for low self-esteem in autistic individuals.

This review therefore aims to address the following questions:

- What does the current literature show about levels of self-esteem in autistic adults?
- What factors have been found to be associated with levels of self-esteem in autistic adults?
- What is the quality of the research currently available about the relationship between autism and self-esteem?

3.2 Method

This review was registered on PROSPERO (ID: CRD 42023457124) and adhered to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (Page et al., 2021).

3.2.1 Search Strategy

The search terms and strategy were tested and refined to reduce the likelihood of missing any relevant papers, and to ensure sufficient balance of breadth and specificity. This was done with the assistance of a librarian. In March 2025, the searches were run on PubMed, CINAHL, and OVID (including MEDLINE, PsychINFO, and EMBASE).

The search terms were Autis* OR Asperger* AND self-esteem OR self-worth OR self-regard. Related terms such as self-concept and self-confidence were not included, because although there may be considered some overlap, they represent distinct phenomena. E.g., self-concept refers to the ideas one holds about themselves, whereas self-esteem is specifically referring to the view of one's worth.

3.2.2 Eligibility Criteria

Studies were considered eligible if they met the following criteria:

- Original research articles of a quantitative or mixed methods design.
- Use of a validated measure of self-esteem.
- Autistic participants (including co-morbid disorders with the exception of an intellectual disability).
- An adult sample (16 years and over).

- Published since the year 2015.
- Published in English, with the full text available for download.

The review set a minimum age of 16, as this is when individuals are considered to have the capacity to consent to take part in research (Health Research Authority [HRA], 2024). In addition, self-esteem differs according to the developmental period (Orth et al., 2018). A time limit of the last ten years was set due to the rapidly changing conceptualisation of autism in recent years (Happé & Frith, 2020), meaning it may not have been comparable to include older studies. Co-morbidities in autism are high, so this was not an automatically excluded as a purely autistic sample would likely have been difficult to recruit, however intellectual disability was excluded due to the potentially significantly confounding impact this may have on outcomes.

Studies were excluded from the review for the following:

- Book chapters, editorial letters, literature reviews, medical studies, intervention studies.
- Purely qualitative designs.
- Participants with a diagnosis of intellectual disability, or another neurodevelopmental disorder in the absence of autism.
- Published prior to 2015.

Grey literature was not excluded from the review to minimise a publication bias.

3.2.3 Study Selection

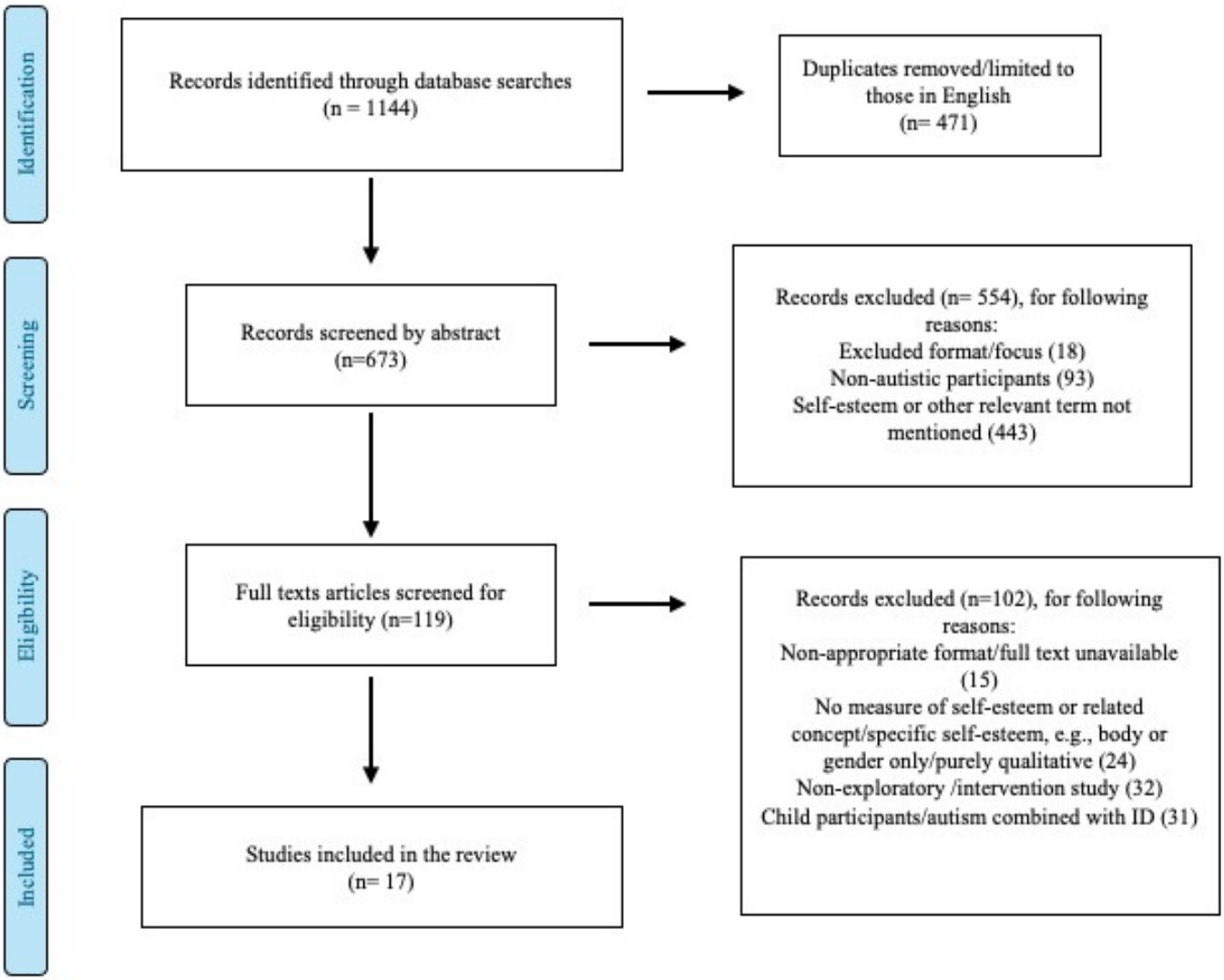
The primary author and second reviewer undertook the study screening (figure two). Titles and abstracts were screened for relevance according to the eligibility criteria. If a decision was not able to be taken based on the abstract alone, the paper was taken through to the next stage. 20% of papers were dual screened by both reviewers (n=137), and inter-rater reliability calculations showed agreement on 97.81% of papers (Cohen's k = 0.91), at an acceptable level of consistency (Siddaway et al., 2019). As such, the remaining papers were screened by the primary author. Disagreements were resolved through discussion (n=3).

Papers meeting the inclusion criteria progressed to the next stage, where they were read in full. The second reviewer read 25% of the full texts (n=30), and inter-rater reliability was again found to be acceptable (100% agreement, Cohen's kappa = 1).

3.2.4 Data Extraction

The following data was extracted from each study: author, title, publication year, country, aim, study design, inclusion and exclusion criteria, participant demographics (e.g., sample size, age, gender, ethnicity), recruitment strategy, mechanism of autism diagnosis, self-esteem measure used, use of a comparison/control group, self-esteem analysis and outcomes, any other relevant outcomes. All data was extracted by the primary author, and 30% by the second reviewer. Upon comparing the data extracted by both reviewers, an inter-rater reliability calculation was found to be acceptable (Cohen's k = 0.967). Disagreements were resolved through discussion.

Figure 2. *PRISMA diagram of screening process*



3.2.5 Quality Assessment

Due to the exploratory nature of the research question and the broad scope of the studies included, the Kmet et al., (2004) Standard Quality Assessment Criteria for Evaluating Primary Research Papers from a Variety of Fields ([QualSyst], table one) was used to generate a quality score for all papers included in the review. There are 14 criteria included, which can be met, partially met, not met, or not applicable in some circumstances. The checklist itself does not have thresholds, as to promote flexibility of the tool (Kmet et al.,

2004), however it is recommended that a cut-off score of 0.75 and over be applied (Kmet et al., 2004). As is common practice across the literature, thresholds have been introduced for this review. A score of 0.75 and above will be considered a good quality study, 0.55 - 0.74 as moderate quality, and 0.54 and below as low quality (e.g., Papatzikis et al., 2023; Dalmaso et al., 2024). No papers were excluded as a result of the quality assessment.

TABLE 1. *QualSyst criteria for quantitative studies (Kmet et al., 2004)*

Item number	Criterion for quantitative studies	Scoring
1	Question or objective sufficiently described?	Yes = 2 Partial = 1 No = 0
2	Design evidenced and appropriate to answer the study question?	Yes = 2 Partial = 1 No = 0
3	Method of subject selection (and comparison group selection, if applicable) is described and appropriate?	Yes = 2 Partial = 1 No = 0 NA
4	Subject (and comparison group if applicable) characteristics/variables/information sufficiently described?	Yes = 2 Partial = 1 No = 0
5	If random allocation to treatment group was possible, is it described?	Yes = 2 Partial = 1 No = 0 NA
6	If interventional and blinding of investigators was possible, is it reported?	Yes = 2 Partial = 1 No = 0 NA
7	If interventional and blinding of subjections to intervention was possible, is it reported?	Yes = 2 Partial = 1 No = 0 NA
8	Outcome and (if applicable) exposure measure(s) well defined and robust to measurement/misclassification bias? Means of assessment reported?	Yes = 2 Partial = 1 No = 0 NA
9	Sample size appropriate?	Yes = 2 Partial = 1 No = 0 NA
10	Analysis described and appropriate?	Yes = 2

Item number	Criterion for quantitative studies	Scoring
		Partial = 1 No = 0 NA
11	Some estimate of variance (e.g., confidence intervals, standard errors) is reported for the main results/outcomes	Yes = 2 Partial = 1 No = 0 NA
12	Controlled for confounding?	Yes = 2 Partial = 1 No = 0 NA
13	Results reported in sufficient detail?	Yes = 2 Partial = 1 No = 0
14	Do the results support the conclusions?	Yes = 2 Partial = 1 No = 0

3.2.6 Data Synthesis

A narrative review design was adopted due to the broad, exploratory nature of the research questions. As such, the results of each study are synthesised, relationships between studies are explored, and then the robustness of the synthesis is assessed (Rodgers et al., 2009).

At the end of screening, 17 papers were included and analysed in the review. A summary of these can be found in appendix B.

3.3 Results

3.3.1 Design

As this review aimed to synthesise the current knowledge around self-esteem in autistic people, and the factors that affect it, most of the included studies were exploratory in nature. They focused on developing an understanding of the relationship between variables, rather than testing the effectiveness of any intervention. This is in keeping with frameworks recommending the studies included in a review align with the type and scope of the research question (Booth & Grant, 2009).

As such, there were no randomised controlled trials in the review and only one that involved an experimental (behavioural) element. This was the study by Chandler et al., (2019), which included a compliance task. All 17 studies were cross-sectional in nature, in that they studied their phenomena at a certain point in time. No studies included a longitudinal element. All of the studies were also correlational, examining the relationship between variables without manipulation. Four were a between-groups design, incorporating a control group of non-autistic participants for comparison. Walker (2023) set out to conduct a between-groups study but was only able to obtain the sample size to achieve this for some of the analyses.

Three studies were mixed methods, with a qualitative component such as focus groups. The results of these will not be synthesised here.

3.3.2 Sample Characteristics

All studies recruited autistic participants. Many required participants to be formally diagnosed by a mental health professional using the diagnostic classification of the country in question (n=5), although this was self-reported. Others also permitted individuals who were

seeking a diagnosis (n=1) or were self-diagnosed or identified with autistic characteristics (n=6) to participate. Four studies used the Ritvo Autism Asperger Diagnostic Scale - Revised ([RAADS-R], Ritvo et al., 2011), the Autism Spectrum Quotient - 10 ([AQ-10], Allison et al., 2012), or a screening interview with a clinician to confirm the presence of symptoms. Tsermentseli (2022) was the only study that required participants to provide a letter from their GP confirming a diagnosis.

Most studies employed mixed strategies for recruitment, with the majority primarily recruiting participants online through relevant forums and websites (n=9). Others also recruited from clinics or other organisations providing services to autistic people (n=8). Only McDonald (2017) specified an incentive of a chance to win a $100 Visa card to take part.

Four studies involved a control or comparison group of ‘typically developing’, or non-autistic participants, all recruited from undergraduate university pools, and a proportion through social media as well. Two studies specified that controls were matched on age (Nguyen et al., 2020; Tsermentseli, 2022), and Nguyen et al., (2020) also matched on sex and education. Chandler et al., (2019) stated that the autistic and non-autistic sample did not significantly differ on age.

All studies were done in adult populations, with the majority specifying participants aged 18 or over (n=15). The oldest mean age of the samples was in Walker (2023) at 42.2, and the youngest in Marion et al., (2023) at 25.12. Cooper et al., (2017) and Cooper et al., (2020) allowed participants aged 16 and over to participate, and Tsermentseli (2022) was the only study to set an upper age limit of 45. This was because evidence has shown that physical and

mental health difficulties in autistic adults are higher in older adults than younger ones, and the author did not want this to affect the interpretation of results.

All 17 studies collected and reported on gender which was mixed. Twelve studies collected some sort of data referencing level of education, and nine studies collected data at the recruitment stage regarding whether participants had another mental health or neurodevelopmental diagnosis or were on medication for such.

Seven studies collected data on race or ethnicity, and across these seven, participants were overwhelmingly White, although Black African, British, and Caribbean, and Asian, mixed, or multiple ethnicities were also reported.

3.3.3 Self-Esteem Measure

Fourteen studies assessed self-esteem using the Rosenberg Self-Esteem Scale ([RSES], 1965). This is not surprising considering it is the most widely used scale for measuring global self-esteem (Moksnen et al., 2024). Consisting of ten items, it is a self-report measure with good validity and reliability (Rosenberg, 1965). Marion et al., (2023) used an adapted version with a reduced number of items (six) and simplified language. Two studies used translated versions of the RSES, Arwert et al., (2020) in Dutch, and Soffer et al., (2021) in Hebrew.

Cooper et al., (2017) and Cooper et al., (2020) also used the Private and Public Collective Self-Esteem Subscales (Luhtanen & Crocker, 1992). This eight item self-report scale measures beliefs about how positively or negatively a group is viewed by society and by the individual, and it has been found to be valid and reliable (Cooper et al., 2017). The two

studies adapted the scale to measure collective self-esteem in autistic people, towards their autism.

Ferenc et al., (2022) utilised the ten-item global self-esteem scale of the Multidimensional Self-Esteem Inventory ([MSEI], O'Brien & Epstein, 1998), translated into Polish. This self-report scale has good correlation with the RSES (Ferenc et al., 2022), and is valid and reliable (O'Brien & Epstein, 1998). It is not clear why this measure was chosen, as the dimensions scale of the MSEI was not used, and it is this element that provides more nuanced information related to self-esteem when compared to the RSES.

Finally, Pyszkowska et al., (2025) used the Self-Competence/Self-Liking Scale – Revised ([SCLS-R], Tafarodi & Swann, 1995), translated into Polish. This is a valid 16 item self-report measure assessing two dimensions of self-esteem: self-competence and self-liking (Tafarodi & Swann, 1995).

Every study measured self-esteem as a self-reported construct, meaning that all participants included will have been required to be verbal, and relatively functionally able, particularly related to language comprehension and expression and understanding conceptual ideas. These requirements may not apply to all autistic people, and therefore likely represent a particular subset of the population.

3.3.4 Quality Analysis

Appendix C shows quality ratings for all included studies using the QualSyst (Kmet et al., 2004). Generally, included studies were of good quality, with one being scored as moderate, and a range of summary scores between 0.68 and 0.95. All met the criteria for a sufficiently

described research question, and at least partially for a clear and appropriate design, appropriate outcome measures, analysis, reporting, and conclusions.

All studies at least partially met the criteria around subject selection, but several studies lost points for grouping together participants with a confirmed formal diagnosis of autism, and those who were self-diagnosed, or who did not have a formal diagnosis but felt they could identify with the characteristics of autism. Likewise, several studies lost points on the sample size criteria, because they did not explicitly state an analysis of power or effect sizes.

Due to the nature of the study designs, all studies were ‘not applicable’ for random allocation to treatment group and blinding of investigators and subjects. For some cross-sectional surveys of some groups, the criteria of controlling for confounds was also less applicable, although some studies did state controlling for variables such as sex, age, and depression and anxiety scores.

3.4 Summary of Findings

As there was very little variation in quality scores for the included papers, with all but one rated as good, individual quality scores will not be regularly referred to in the summary.

3.4.1 Rates of Self-Esteem in Autistic People

Of the four studies that included a control group of ‘typically developing’ participants, all found that autistic individuals had significantly lower self-esteem than those who were not autistic (F [4, 527] = 29.34, $p < .001$, [Cooper et al., 2017]; t [50] = 3.10, $p = .003$, $d = -.86$, [Chandler et al., 2019]; F [1, 133] = 4.08, $p = .045$, [Nguyen et al., 2020]; t [117] = −2.122, $p < .05$, [Tsermentseli, 2022]). This continued to be the case when controlling for sex,

sexuality, and education (Cooper et al., 2017). In the study by Pyszkowska et al., (2025), results also showed that self-esteem was lower in autistic participants and those with a dual diagnosis of autism and attention deficit hyperactivity disorder (ADHD) compared to those with ADHD alone.

While Cooper et al., (2017) also found a significant effect for sex, with self-esteem being lower in women (F [1, 527] = 5.15, < p .05), this was not supported across studies. For example, Arwert et al., (2020) did not find this effect, although they had a much smaller sample. For collective self-esteem, that is a positive view of a group or shared identity, there was no significant effect of age (β = -.53, p = .36) or sex ([β = -1.20, p = .06], Cooper et al., 2020). Cooper et al., (2017) also found that those who were more highly educated autistic adults had higher levels of self-esteem (F (1, 527) = 15.21, < p .001).

3.4.2 Factors Associated with Self-Esteem in Autistic People

In the study by Corden et al. (2021), higher psychological wellbeing, sex, age at diagnosis and the recency (longer duration since diagnosis) explained a significant amount of the variance in self-esteem ([77.1%], F [5, 141] = 95.21, p < 0.001). In particular, lower dissatisfaction with being autistic (r = -.738, p < .001) and higher wellbeing (r = .592, p < .001) were found to be significantly associated with higher self-esteem. Ferenc et al., (2022) supported the findings regarding recency of diagnosis, with a later in life diagnosis significantly predicting lower self-esteem (p < .01), and Longhurst et al., (2024) supported evidence that wellbeing (r = .70 for women, r = .67 for men, p < .001) and psychological quality of life (r = .76 for women, r = .59 for men, p < .001) are significantly positively correlated with self-esteem.

Furthermore, in autistic people, self-esteem was found to be significantly negatively associated with a suicide attempt history ($F = 7.26$, $p = .01$), although the direction of causality is unclear. Self-esteem was also related to the degree of current suicidality, but only through its contribution to depression ([β = -.032, p = .809], Arwert et al., 2020).

Other factors found to be related to increased self-esteem in autistic people included greater body appreciation ([$r = .76$ for women and $r = .71$ for men, $p < .001$], Longhurst et al., 2024), indicating that physical components also contribute.

In addition, perceived social support was significantly positively associated with higher self-esteem in autistic adults (r = .54, p < 0.001), as was perceived giftedness, invulnerability, and power, even when controlling for autistic characteristics ([sr2 = .03 – .08], Nguyen et al., 2020). Tsermentseli (2022) also investigated social support, finding a positive correlation between self-esteem and social support (r = .380, p < .01), as well as self-esteem moderating the relationship between social support and life satisfaction ([38.3%], β = .505, t = 5.563, p < .001).

Zimmerman et al., (2017) found a significant correlation between matrix reasoning and self-esteem when controlling for sex, age, and years of education. Specifically, stronger non-verbal reasoning was related to poorer self-esteem ($r = -.36$, $p < .05$), as was executive functioning assessed using the D-KEFS-2 ([Delis-Kaplan Executive Function System – 2; Delis, Kaplan, & Kramer, 2001], $r = -.40$, $p < .05$), and social inference ($r = -.39$, $p < .05$). While acknowledging that this may appear counterintuitive, it also suggests that individuals with higher cognitive and social abilities are more aware of the difficulties associated with being autistic, leading to reduced self-esteem (Zimmerman et al., 2017).

Lower self-liking in autistic participants was also found to significantly negatively predictive of maladaptive daydreaming ([B = -1.55, p < .001], Pyszkowska et al., 2025), postulated as a form of escape-based coping.

3.4.3 Autistic Identity

Eight studies included some exploration of the effect of autism social identification on self-esteem in autistic adults. A sense of belonging to the identity of ‘autistic’, was found to be significantly positively associated with collective self-esteem (β = .43, p < .001), and collective self-esteem with personal self-esteem ([β = .41, p < .001], Cooper et al., 2017). This was supported by Cooper et al., (2020), who also found a significant positive relationship between autism identification and collective self-esteem, whilst controlling for gender and age (r = .52, p < .001). There was also a significant but indirect relationship between valence of autism scores (calculated from the positive and negative attributes autistic participants associated with autism) and collective self-esteem, in that it increases autism social identification ([β = .21], Cooper et al., 2020). Similarly, Corden et al., (2021) found that a greater sense of autism pride was predictive of higher self-esteem (r = .592, p < .001).

Moreover, autistic participants who perceived themselves as more similar to ‘prototypic’ members of the autism community had higher psychological distress and lower self-esteem ([B = -.10, SE = .05, p = .04], Ferenc et al., 2022). Ferenc et al., (2022) also found that autistic individuals who perceive their diagnosis as aligning more with a neurodiversity paradigm have higher self-esteem (B = .06, SE = .02, p = .01), compared to a medical disorder or ‘pathology’ perspective, which has been found to be negatively correlated ([t_b [128] = -.13, p = .046], Walker, 2023). However, Walker (2023) did not corroborate a

significant relationship directly between self-esteem and the neurodiversity paradigm, instead finding that the concepts were linked via their relationship with internalised stigma and acceptance.

Similarly, identification with autism characteristics was found to be negatively associated with self-esteem ($r = -.27$, $p = 0.023$), while greater acceptance of the diagnosis and perceiving more benefits as a result was significantly positively associated with higher self-esteem ($r = .57$, $p < .001$; $r = .58$, $p < .001$), as was lower helplessness ([$r = -.47$, $p < 0.001$], Nguyen et al., 2020). This was considered to be due to a higher sense of control over one's identity.

Regarding how autistic individuals choose to label themselves, Soffer et al., (2021) found no significant difference in self-esteem between those who self-label as having Asperger's, compared to Autism Spectrum Disorder (t [77] = 1.07, $p = .29$).

3.4.4 Stigma and Autism

Four studies measured stigma towards autism in some way, and Soffer et al., (2021) found a significant negative correlation between perceived public stigma and self-esteem ($B = -.34$, $p = .01$). More specifically, Marion et al., (2023) found that a greater reported stigma upon disclosure of their diagnosis, was significantly correlated with lower self-esteem in autistic adults ($p < .5$), although interestingly discrimination was not ($p = .37$). This is perhaps surprising, however may suggest that internal processes are more impactful on self-esteem than external, or that there is an unknown mediator at play. McDonald (2017) found that the concepts of stigma and self-esteem while related, were distinct enough to represent different items on an identity scale.

Zhuang et al., (2024) also found that self-esteem significantly mediated the relationship between perceived autism stigma and camouflaging, in that more perceived stigma was related to lower self-esteem and higher camouflaging behaviours (b = .12, SE = .08, p = .032). Camouflaging is when an autistic person attempts to hide their autistic traits or behave in a way that may be perceived as more neurotypical, postulated as a way of conforming socially. Interestingly, results from Zhuang et al. (2024) also showed that greater self-construal (how independent or interdependent one views the self) was associated with higher self-esteem and *more* camouflaging (b = .42, SE = .16, p = .007). Authors suggest camouflaging in this case may be a deliberate, protective behaviour, to avoid any unwanted consequences of being perceived as autistic, which when successful boosts self-esteem.

A particular form of stigma, bullying, was explored by Triantafyllopoulou et al., (2022) in autistic people, specifically in an online context. Being the victim of cyber-bullying, particularly having one's personal information posted online (r [75] = -.25, p = .03), and being excluded or ignored by people online (r [75] = -.29, p = .01) was significantly associated with poorer self-esteem. Conversely, appearing to act as protective factors, self-esteem was positively related to the number of online friends (r [77] = .27, p = .02), and considering oneself as part of an online community (r [77] = .29, p = .01).

3.5 Discussion

3.5.1 Research Questions

Regarding the first aim of this review, summarising the current literature on the rates of self-esteem in autistic adults, it is clear that self-esteem is reduced when compared to the general population. This has negative consequences, including suicidality and poorer wellbeing. For

the second aim, several factors were shown to impact this relationship, for instance a sense of autism pride and identification, and stigma.

For the third and final aim, considering the quality of the current research, assessment using the QualSyst showed that the research quality for included studies was generally good, however future research should be clear about issues around recruiting autistic participants and statistical power in the analysis.

3.5.2 Study Limitations

The majority of the studies were of a cross-sectional, correlational design, which was appropriate for the review objectives. However, while significant correlations and relationships between variables were established, it is not possible to ascertain the direction of these relationships or the cause. The wide use of the RSES could also be potentially limiting, as it does not capture the nuances in the different domains of self-esteem and may be subject to a social desirability and cultural bias (Mesmer-Magnus et al., 2006; Wu, 2008).

Another limitation across several studies is that the possibility that the samples were not a homogenous group. Even in those who required participants have a formal diagnosis of autism to take part, this was mostly self-reported. Of the studies included, only one specified that removing self-diagnosed participants from the analysis did not significantly change the results (Cooper et al., 2017). In addition, as the participants included were verbal and of a level of functional ability to consent to and take part in the research, this will have excluded autistic individuals who are not in this group, and therefore results cannot be considered to be representative of the autistic population as a whole.

Only Longhurst et al., (2024) presented results according to sex, and it is well established that autism presents differently in females (Schuck et al., 2019). Although most studies did not present data on race, of those that were known, the sample was overwhelmingly White. As such, results may not be representative of the autistic population as a whole. In addition, for those whose self-esteem is so poor they do not accept or disclose their diagnosis, there may have been a selection bias at play.

While most studies were clear that an intellectual disability was an exclusion criterion, some did not explicitly state this, nor were other comorbidities excluded. Cooper et al., (2017), Zimmerman et al., (2017), Chandler et al., (2019), Arwert et al., (2020), Nguyen et al., (2020), Corden et al., (2021), and Soffer et al., (2021) all also collected data using a measure of depression and anxiety, although only Cooper et al., (2017) and Soffer et al., (2021) explicitly stated that they controlled for these variables in the analysis. Pyszkowska et al., (2025) was the only study that directly compared autistic participants with those with ADHD and comorbid autism and ADHD. The literature is clear that neurodiversity comorbidities are common (Bonti et al., 2024), as are comorbid mental health conditions (Curnow et al., 2023), but these may still be confounding findings related to self-esteem.

3.5.3 Review Limitations

Because of the broad nature of this narrative review, a flexible and generalisable tool was used to assess the quality of the included studies. However, the QualSyst is not specific to the field of autism, or even mental health, and may therefore lack the nuance to fully assess the methodologies. In addition, there is suggestion that the scoring system, particularly the equal weighting of criteria and a total numerical score, may be oversimplifying the interpretation of

the studies and therefore be misleading about overall quality (Kmet et al., 2004; Migliavaca et al., 2020).

Furthermore, this review was limited to studies published in English. While there were a range of countries including Poland, Australia, Israel, and the Netherlands included, this may not be reflective of the relationship between autism and self-esteem in other countries, particularly non-western ones.

3.6 Conclusion

In summary, this narrative review provides evidence that poor self-esteem is prevalent in autistic adults, more so than the general population, and may be a focus for intervention. Self-esteem is associated with a reduced quality of life in various domains and has clinical implications for mental health. Factors such as a strong positive autism identity and relating with a neurodiversity paradigm appear protective. Longitudinal follow-ups and experimental designs that may point to direction of causality would be a useful area for future research.

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Service Improvement Project: Exploring Sexual Rights vs. Sexual Safety in a Community Intellectual Disability Service

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Supervisors have read and provided feedback on this work and deem it suitable for assessment.

The proposed publication journal for this work is the British Journal of Learning Disabilities due to its commitment to dialogue with people with intellectual disabilities and their families, carers, allies, and advocates. This paper has therefore been formatted according to the journal guidelines (appendix D).

Abstract

Background: Concerns around the safety of service users with an intellectual disability has meant that they have been overly restricted, which is not in line with current policy or theory. This paper aimed to establish how a community learning disability team maintain the balance between sexual rights and sexual safety. **Method:** Three main themes were derived from staff interviews using thematic analysis: communication, confidence and competence, and standardised vs individual. **Findings:** Recommendations were made based on staff's sharing of their experiences and identified enablers and barriers. These are shown alongside the response from the service. Implications and limitations are discussed. **Conclusions:** This topic can be anxiety-provoking and staff feel a sense of responsibility. Empowering service users is a strength within the team, but implementing recommendations that improve confidence and competence may be useful.

Keywords: *intellectual disability, learning disability, sexual rights, sexual safety*

4.1 Introduction

4.1.1 Summary of Relevant Literature

An intellectual disability (ID) is characterised by intellectual and adaptive functioning significantly below the average for the developmental period (6A00, World Health Organisation [WHO], 2019). For services which work with this population, considerations around capacity and consent are inherent. In a wider context, a report by the Care Quality Commission (CQC) in 2018 identified significant issues around sexual safety on mental health wards, which has made the topic a policy priority (CQC, 2018).

The balance between an individual's right to appropriate sexual expression and issues of safety such as exploitation, consent, and risk, creates a conflict on a service level (Dukes & McGuire, 2009). Behaviours related to sexual interest and sexual maturity may alarm carers, and restriction around this, particularly related to pregnancy in women, has been a historical element of eugenics (Servais, 2006; Roy et al., 2012). Sexuality is defined as 'the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence', and this 'contributes to people's overall sense of well-being and health' (World Health Organization, 2015, p4.)

It was not until the normalisation movement of the 1970's that individuals with an ID were recognised as sexual beings (Aunos & Fledman, 2002; Dionne & Dupras, 2014). McGuire and Bayley (2011) maintain that whilst there has been a move towards person-centred care for this group, sexuality and relationships are behind on a practical level. Individuals with ID's have fewer opportunities to pursue intimate relationships, are less likely to have had sex,

and are more likely to have unsafe sex or be sexually abused (Baines et al., 2018; Carter et al., 2021; Svae et al., 2022). Moreover, there has been a historic holdover of individuals with an ID being seen in extremes of either asexual, or sexually obsessed (Wilson et al., 2011).

Evidence suggests people with an ID have less experience and knowledge in areas related to intimate relationships compared to the general population, including around contraception and consent, which is a fundamental element of the legal capacity to consent in the UK (Mental Capacity Act [MCA], 2005; Murphy & O'Callaghan, 2004). As such, individuals with an ID are at higher risk of misinformation, sexual abuse, and poor sexual health (McDaniels and Fleming, 2016).

Restrictive practices have been under increased scrutiny since the publicised Winterbourne View scandal of 2011 (The Royal College of Psychiatrists, 2018). In addition, O'Brien's five accomplishments (1992) outline areas in which a service for individuals with ID should operate in, to enhance the quality of life for their service users. These are community presence, choice, respect, relationships, and competence (Murray et al., 1998). Opportunities to pursue sexuality and relationships is essential for meeting these criteria, and evidence suggests that this is still not always being fostered in individuals with an ID, due to social devaluation and exclusion (Wolfensberger, 1983). As such, restrictive measures around sex for people with ID remain common (de Wit et al., 2024), and more restrictive attitudes have been shown to have a negative impact on sexual health and safety (Servais, 2006), in part because they shut down discussion and increase the likelihood of acts taking place in secrecy.

For risk posed to others, prevalence rates of ID are higher in offending populations compared to the general population and there is some suggestion that sexual offences are

overrepresented (Craig, et al., 2006; Jones & Chaplin, 2017). Furthermore, research shows that individuals with an ID who sexually offend have higher levels of sexual knowledge that those who do not (Michie et al., 2006). When sexual risk is posed by an individual with an ID it is therefore necessary to disentangle true intent to offend from a counterfeit deviance, that is behaviours that may appear inappropriate but serve another function (Hingsburger et al., 1991).

While research indicates that staff supporting individuals with an ID are aware of the personal right to sexual autonomy, attitudes remain prohibitive (McGuire & Bayley, 2011). Even amongst those who possess generally accepting attitudes towards sexuality, these often include a preference for platonic, friendship-like relationships with minimal intimacy (Correa et al., 2022).

While this may be in part due to staff being protective, Grace et al., (2017) found that they also appeared to be attempting to maintain their authoritative position. In response, service users felt restricted and were of the belief that they required permission, which was often conditional and somewhat inconsistent. Participants also reported that the rationale behind this was often not explained to them, emphasising the power differential between themselves and staff.

The views of staff are important, as evidence shows the beliefs of those around them have more of an impact on individuals with an ID than their own (de Wit et al., 2022). Due to the nature of support offered to these individuals, they may naturally look towards carers for their guidance and views (Deffew et al., 2022). Prohibitive attitudes, therefore, can lead to individuals with an ID holding a belief that sexual relationships are not something they are

permitted to engage in (English et al., 2018). In addition, they have been previously thought of as ‘eternal children’ and have been kept deliberately misinformed to reduce the likelihood of them engaging in sex due to fear (Kempton et al., 1991; Servais, 2006; English, 2018; de Wit et al., 2022).

People with an ID need support and education to have healthy sex and relationships, and staff should have appropriate skills and materials to discuss this with them, considering it an important part of their role (Medina-Rico et al., 2018; Charitou et al., 2020). De Wit et al., (2022) maintain that positive sexual health is not yet something that is routinely provided by systems of support for individuals with ID, despite the established need (Deffew et al., 2022).

Previous studies have revealed that staff feel unsupported and frustrated in this area, that more training and clearer guidelines are needed for them to offer this kind of support, and that they fear being held accountable for any consequences (Wilson et al., 2011; Dewffer et al., 2021; de Wit et al., 2022). Staff also feel that discussions around this topic are reactive in nature (Deffew et al., 2022), and they worry about having the right words to have conversations about sex and relationships with people with an ID (Schaafsma et al., 2017).

Literature indicates that care staff are in support of rights and autonomy, but still perceive it to be risky, challenging, and anxiety provoking on a personal and systemic level (Charitou et al., 2020). Charitou et al., (2020) suggest ID services develop specific policies related to sexuality and relationships to preserve rights in this area. Many studies advocate for training for staff, and indeed this has been linked to more positive attitudes around sexuality and ID (Correa et al., 2020). However, some go further, and recommend training be linked to specific

policies and roles, and that reflective spaces, specific supervision, and modelling by senior staff members is introduced (Charitou et al., 2020).

There exists then, a difficult balancing act for staff whereby service users are empowered about their sexual rights, but also protected from harm (Murphy & O'Callaghan, 2004; Deffew et al., 2022; de Wit et al., 2024). Fundamentally, people with an ID are interested in sex and intimacy and have a right to explore this (Correa et al., 2022), but this is not always being facilitated in services.

4.1.2 Outline of Service Improvement Project

The rationale for this service improvement project (SIP) is that the literature is illustrating a challenge for individuals with an ID to express their sexuality according to their rights, in part due to the risk of harm (Brown & McCann, 2018), despite this being in line with policy around person-centred care (NHS England, 2015).

Community Learning Disability Teams' (CLDT's) provide support to adults with a diagnosed ID, whose needs cannot be sufficiently met elsewhere. Support is offered in physical health, mental health, daily living skills, and communication and eating support. This SIP was conducted in the Oxfordshire CLDT, comprised of a multi-disciplinary team including nursing, occupational therapy, psychology, psychiatry, and speech and language therapy.

Through an iterative process of discussing relevant issues with key stakeholders in the team, primarily senior staff members, the topic of sexual safety and risk was determined to be of practical relevance and in line with current policy. Initially, there was a query around the difficulty in managing issues related to service users open to the team who posed a forensic

risk, but consultation with the wider team indicated that sexual risk as it applies to the population more generally was a concern shared by many disciplines and was appropriate for a SIP.

4.1.3 Aims

The aim of this project was to build on previous research and establish how the balance between upholding service user's sexual rights and managing sexual risk is maintained within the Oxfordshire CLDT.

This was achieved by collating the data around sexually risky incidents, and exploring the issue with staff, to develop a better understanding of the problem around perception of sexual risk in this population. This was followed by a process of generating ways in which this might be improved and feeding this back to the team.

The outcome of this project was expected to be:

- Increased understanding of the importance for services to balance sexual rights with sexual safety in individuals with an ID.
- Establish the difficulties involved for teams in maintaining this balance, and what actions they are currently taking to do this.
- To provide a list of recommendations for the service and potential future quality improvement (QI) projects.
- Contribute to evidence that informs policy aiming to reduce restrictive practices towards individuals with an ID, ensuring service users rights around sexual expression are upheld.

4.2 Method

4.2.1 Phase 1: Data Collection

This project was approved by the Oxford Health Foundation Trust Forensic and Learning Disability Quality Improvement Hub. The first stage involved collection of reported incidents categorised as sexually risky, as part of routine data collection for the service. This was presented to participants during interviews to establish if it felt reflective of their experience. Data was collected over approximately a two-year period, as this coincided with the introduction of a new incident reporting system (1st January 2022 – 31st December 2023).

Nine incidents of a sexually risky nature relating to service users under the Oxfordshire CLDT were reported in the specified period. Six were categorised as ‘minor’ or ‘low’ harm, and three ‘no harm’ or ‘near miss’. Harm is categorised according to level of actual physical harm resulting from the incident. There is no addition guidance on defining what constitutes a sexually risky incident, this is left up to the individual member of staff completing the report to determine, usually the service user’s key worker. Five reports include details of safeguarding reports, and six reports to the police in response.

4.2.2 Phase 2: Interviews

All staff were invited to take part in semi-structured interviews. The team consists of 69 staff members in total, 23 of whom are of a nursing background, 13 occupational therapy, and 14 psychology (not including trainee clinical psychologists on placement). These roles are distributed between bands five to eight. Six staff members gave informed consent and demographics are presented in table’s two and three. Psychiatry and speech and language therapy were not represented.

Table 2. *Participant demographic information*

	Frequency	**Percentage (%)**
Gender (6 responses)		
Female	4	67%
Male	2	33%
Non-binary	0	0
Other	0	0
Prefer not to say	0	0
Age (6 responses)	3	50%
18-29	1	17%
30-39	2	33%
40-49	0	0
50-59	0	0
60+		
Years of experience in Learning Disability (6 responses)		
<1 year	0	0
1-5 years	3	50%
5-10 years	2	33%
10+ years	1	17%

Table 3. *Participant characteristics*

	Open responses
Professional background (6 responses)	‘Psychology’ ‘Psychology’ ‘Occupational Therapist’ ‘Occupational Therapist’ ‘LD Nurse’ ‘Learning Disability Nurse’
Pay band (6 responses)	‘Band 5’ ‘5’ ‘6’ ‘6’ ‘6’

	Frequency	Percentage (%)
	‘8a’	

It should be noted that in the data extracts, the terms learning disability (LD) and intellectual disability (ID) are used interchangeably.

A semi-structured interview schedule (appendix E) explored participants views on the importance of the balance between sexual rights and sexual safety, how they currently maintain this, factors that act as barriers and supporters, and any additional resources staff members believe would better enable them to do this. This interview schedule, along with the recruitment and dissemination processes, was informed by a staff member acting as expert by experience. This staff member was excluded from taking part in an interview.

Interviews took place online, lasting from 32 to 44 minutes. Member checking was then conducted, to improve the credibility of the themes derived from a relatively small sample. Member checking can provide evidence that the content of the data and the interpretation arising from the analysis is accurate, when it has not been possible to reach full data saturation (Lincoln & Guba, 1985). The team were presented with initial themes and asked for additional thoughts and context. Five staff members engaged in the member checking, but all staff members present had the opportunity to contribute.

Data from phase one was presented to participants who were interviewed. They generally agreed that the recorded frequency and severity of the reports reflected their experience of working with sexual risk in the team. This was despite sexually risky behaviours being described as causing much ‘*angst*’ (MC1). Some felt that for the population they support, the risk reporting system was not fit for purpose, and that they were often trying to prevent

perceived problems from occurring, rather than responding to them. Participants also described that the categorisation of the risk was unwieldy:

> *'the level of harm, I would say no, I don't think that matches it, but I think people have completed the boxes in a way the system tells you to.*
> *Because it's like, have your arms and legs fallen off and no, they haven't. It's just you've got permanent PTSD kind of thing'* (P3).

A reflexive thematic analysis approach was undertaken to analyse the data (Braun & Clarke, 2006; 2022). Thematic analysis is a widely used, accessible, and theoretically flexible approach to analysing qualitative data through coding to generate themes representative of patterns in the data (Braun & Clarke, 2006).

The analysis was inductive, in that all themes came from the data, rather than being driven by an existing framework (Braun & Clarke, 2006). As the research question was exploratory in nature, this approach was considered the most appropriate. In addition, coders searched for latent themes in the data, rather than simply semantic, to start to identify underlying ideas and beliefs that may need addressing when making the recommendations to the service.

A critical realist epistemological position was adopted, which conceptualises reality as existing independent of the participant's and researcher's ideas about it, but that this is mediated by language and culture, and influenced by our own experiences (Braun & Clarke, 2022).

4.3 Findings

Three overarching themes and nine subthemes were worked from the codes established from the data (table four). A second coder from the research team coded two interview transcripts

(33%) in their entirety, to elicit a deeper understanding of the data. Inter-coder reliability was not calculated as Braun and Clarke (2022) maintain this reinforces the idea that themes reside *in* the data, ignoring the researcher's subjectivity, which is an essential element of the reflexive approach.

This stance allowed for interpretive coding of the data, not just at the surface-level (i.e., the content), but also a deeper interrogation to ascertain underlying meanings and beliefs. These latent understandings were shaped by the researcher's subjective position and were constructed into themes through critical and active engagement with the data. This process was supported by reflexive journaling and supervision. For instance, the sub-theme 'fighting the good fight', was not a phrase explicitly said by any of the participants, rather it was derived from a sense gained in the process of facilitating the interviews, that staff were often holding the boundary around their service users' sexual rights, while facing opposing views from the others involved (e.g., families, supported living placements, GP's).

Individual codes and further quotes can be found in appendix F. All identifying information has been removed from extracts to preserve participant anonymity.

Table 4. *Themes and subthemes from interviews and member checking*

Themes	**Subthemes**
1. Communication	Need for education
	Fighting the good fight
	Barriers
2. Confidence and	Anxiety provoking
	Lack of confidence

Themes	Subthemes
competence	Lack of knowledge
3. Standardised vs. individual	Supporting a vulnerable population
	Person-centred care
	Routine assessment

4.3.1 Communication

4.3.1.1 Need for education

Sex education was considered important for the service user, as *'they've not had that opportunity … And I don't think schools give that level of education'* (P1). They may also miss learning that is obtained through developmentally appropriate social experiences, *'for someone for with an LD how do you begin to understand when you've actually put someone at risk because you, you didn't have that understanding of nonverbal consent'* (P5).

Some spoke about the sex and relationships psychoeducational group provided by the service:

> *'Because we're prepping the group at the moment and a lot of that is looking at capacity concern, healthy relationships, unhealthy [relationships], the safety side of things as well as kind of the sexual health and sex itself. So, it really covers all the bases'* (P1).

'The group that we're running is a really big positive and I think it's quite rare for an LD team' (P1). However, not everyone was aware of this *'could there be, you know, a half a session, a session, something in interpersonal relationships that is more like interpersonal relationships and sexual relationships'* (P5).

This was reflected in other codes from this subtheme, for instance the availability of resources:

> *'I think what would have been helpful … would be some sort of resource pack that has all the information around the capacity that you're assessing for and also the imagery because as I was kind of pulling it from lots of different places'* (MC4).

Another participant responded *'It exists. I've got laminated pictures of people having sex in the cupboard'* (MC5).

Participants spoke about teaching their service users to be empowered, and that their role is '*making sure that they can make those choices and advocate for themselves or for someone to advocate for them'* (P6).

4.3.1.2 Fighting the good fight

Participants also fight for service users' rights to be respected: *'we're making it normal and healthy and kind of appropriate for people. And I think that's quite unique'* (P1).

One participant emphasised *'making sure the person's always involved in their care'* (P2), and another *'helping people think about how else they could meet their needs if they wanted to, so they then have more of a choice 'cause I feel often our clients don't have a choice'* (P3).

This linked to the idea of higher standards for individuals with an ID, *'you know, if she didn't have the LD and she was doing that…'* (P1), indicating that some sexually risky behaviours are developmentally normative, and are not questioned when undertaken by someone without an ID but are met with alarm when someone with an ID engages in them.

Participants were aware that shame and stigma are likely feeding into this phenomenon: *'you complicate those feelings with guilt, shame and stigma. And, you know, I can imagine there's probably not much research on that from an LD perspective either'* (P5).

4.3.1.3 Barriers

It was felt that this attitude is not always reflected by other systems, *'several of us have had dealings with GP's of kind of trying to promote that sort of side of things'* (P1), or society at large, *'we've moved on hugely since everyone had to be in residential homes and hidden away from the public. But we've not moved on to mainstreaming properly and something that's practical, right?'*(P3).

Views of family were reported as difficult to navigate, *'they're very protective and they want to keep them safe. But by keeping them safe, they're stopping them from doing anything'* (P4).

Although participants were empathetic:

> *'I have no idea what I would be like, as a parent to someone with a learning disability, and there's also like, how much do you support someone before it becomes a bit unethical as well...as parents or carers, you have to be comfortable talking about this [but] it's also totally fine that you're not comfortable talking about it.'* (P3).

And acknowledged the complexities that come with parenting an adult child with an ID:

> *'if I was living with my parents, they probably wouldn't be facilitating me or helping me to have sexual relationships like that's normal that you don't want to think about your children as sexual beings, especially not children that are vulnerable and you've spent your absolute life fighting to keep safe and have a place in society.'* (P3).

4.3.2 Confidence and Competence

4.3.2.1 Anxiety Provoking

The topic was emotive and anxiety-provoking, especially related to a fear staff may be held responsible for any consequences, *'the feeling of a professional overstepping and putting someone in a risky situation. So we're trying to cover our own back and also protect the person'* (P4).

Participants were very aware of working in the 'grey area' of understanding with their service users, *'consent is quite ambiguous and consent is largely non-verbal. And when you look at like all the percentage of ways people give consent you know it's … how do you begin to understand'* (P5).

And of them being unable to manage this 24/7, *'so even though that they were having this discussion saying what they would do, they were then going into the community by themselves and then doing the complete opposite of that'* (P6).

4.3.2.2 Lack of confidence

Some felt they lacked confidence in this area, especially those who considered themselves to have little experience, *'then it's just familiarizing ourselves and feeling more competent in using it all'* (P6).

Some stated they would not feel confident undertaking this work unless they had another member of the MDT with them, *'I think I'd probably request regardless of what gender I was going to see as a patient, I'd still request to go with someone. I think to realistically to get kind of give that extra protection'* (P4).

4.3.2.3 Lack of knowledge

There was a consensus that access to further knowledge and resources would be helpful, e.g., training, and easy read resources.

One participant wished for an opportunity to share learning, to increase discussions and ideas about how to support service users, *'as a team, what we should maybe be better at doing is when we've had like a case study where there has been this risk and what we put in place, what's going well and what hasn't'* (P6).

Many also felt that it would be helpful to have access to clear processes around sexual risk, contact information for other agencies, and proformas for assessment and risk management. Only one participant mentioned using a risk assessment tool, a 5x5 risk matrix and found that *'with the risk side of things recorded on a document, I think was quite reassuring for us'* (P6).

4.3.3 Standardised vs Individual

4.3.3.1 Supporting a vulnerable population

Participants spoke about their moral and professional responsibility to safeguard individuals: *'Obviously people with learning disabilities are vulnerable people, aren't they? They're vulnerable population of society … sexual abuse is just another one that they just need to be protected from if they're not able to protect themselves'* (P2).

Some appeared to believe that sexual safety was synonymous with the legal capacity to consent, *'what is their level of understanding and linked with the understanding comes the element of consent, so they need to be able to, yeah, tick the boxes for a kind of capacity assessment'* (P4). While others were aware of risk for those who have capacity but are still vulnerable, *'sexual safety for a lot of my clients, they're clients who have capacity, but are vulnerable to exploitation or vulnerable to have difficulties understanding their emotional needs and how to meet them'* (P3).

Participants were also unsure around *'a real difficulty there for us as clinicians when we're aware that people are potentially still engaging in sexual relationships when we've deemed them not to have capacity and then the legal, the legal worries about that'* (MC1).

There was acknowledgement of the weight of this restriction:

> *'I will publicly admit that I actively avoid capacity of sex assessments. I think it's a huge responsibility, you know because it is a human right and human need so to say that someone does not have capacity is a huge responsibility'* (MC2).

4.3.3.2 Person-centred care

Participants used examples to demonstrate how much sexual need and expression varies from person to person, and how this can limit the appropriateness of standardised procedures. *'[I] think it's really individual. That's what makes it difficult … that gets people a bit jumpy because you're like, so what is actually right for this person'* (P3).

4.3.3.3 Routine assessment

Some admitted that it may be useful to know earlier when service users may have a need around sexual rights *'making it more of a sort of a standardised part of the assessment process, maybe not in the first five minutes'* (P5). They felt it is professionals' job to raise this, *'there's probably something quite powerful when taking the onus off the other person to bring up sex … when they know that they're not making a person uncomfortable'* (P5), and, *'I think probably we could ask about it more. I expect it's not in initial core assessments … I think I say we don't mind talking about it, but we don't like to bring it up'* (P3).

This raised ideas about whose job it is to be asking service users about sex. Some participants believed it is a psychologist's job to take the lead, *'I liaised with psychology, consulted with them when doing it. So yeah, that's feel that it kinda sits more psychology'* (P2).

4.4 Discussion

The aim of this SIP was to build on previous research around professional's attitudes towards sexual rights and sexual safety for people with an ID and attempt to establish how the balance between the two is maintained within the Oxfordshire CLDT. Overall, participants spoke more about safety than of rights, perhaps understandably given the evidence indicating that a move towards supporting individuals to explore their sexual rights is viewed as challenging, anxiety provoking, and potentially risky (Charitou et al., 2020).

The findings are consistent with existing literature suggesting that the conceptualisation of capacity in this area is particularly difficult (Dukes & McGuire, 2009), and that professionals feel concerned about the risk of sexual abuse, unsafe sexual practices, misinformation, and sexual ill health (McDaniels & Fleming, 2016; Carter et al., 2021; Svae et al., 2022). Participants also focused more on the risk posed *to* their service users than by them, potentially due to a paternalistic attitude towards where service users are considered 'eternal children' (Kempton et al., 1991). Risk to others was mainly considered in the context of a lack of understanding around appropriateness of behaviours, rather than an offending behaviour with intent, although this may be reflective of the population served by the team in which truly forensically risky individuals are directed elsewhere.

These are important considerations given the research indicating that the attitudes and views of those around an individual with an ID have a substantial influence on them, more than

their own views (de Wit et al., 2022), and negative attitudes have a negative effect on sexual health and safety (Servais, 2006).

The current study sought to add to this by exploring what professionals are doing to keep their service users safe whilst allowing them to express themselves sexually. Participants spoke about utilising their MDT to do this, seeking advice and reassurance, and gaining support for their chosen actions, often using a capacity assessment to guide them. Some participants compared their responses to a non-ID population, to 'check in' with any urge to be potentially restrictive. Only one participant spoke of using specific frameworks (e.g., attachment, trauma-focused) to formulate risky behaviours and consider alternatives.

Participants also spoke of needing to feel confident in their ability to be risk positive, and being sure that the responsibility would not lie solely on them if something were to go wrong. Part of this appeared to be an acceptance that professionals would need to become comfortable with what they cannot control. Several difficulties were identified, including a concern about the legal ramifications around determination of capacity and the subsequent enforcement of this.

Staff were aware that individuals with an ID are sexual beings with a right to sexual autonomy but were sometimes unclear in the boundaries of their professional role in facilitating this. Some strongly felt it was their responsibility to raise the topic and to establish a safe space for discussing the matter. There was also an idea that psychological professions should be taking the lead with this, perhaps due to their training and experience in having difficult conversations.

Participants spoke unanimously of training and formalised processes to aid in their endeavour to maintain the balance between rights and safety, in line with previous research (Deffew et al., 2022; de Wit et al., 2022), and participants felt anxious when this was absent. Processes included routine assessment proformas, structured risk assessments, and flowcharts of relevant tasks and contacts. There was a sense that more resources, structure, and formality would leave less room for professionals to be required to use their clinical judgement and therefore feel safer, so a balance must be reached to meaningfully increase confidence.

Finally, in line with O'Brien's five accomplishments (1992), participants voiced an emphasis on overall quality of life for their service users but recognised that this is practically difficult in some areas, often due to the way people with an ID are perceived on a societal level. For instance, the lack of spaces and opportunities for pursuing intimate connections may mean that individuals with an ID are unable to fully operate in the areas of community presence and relationships, and funding constraints may mean that these are continuing to decrease.

4.5 Limitations

A primary limitation of this study is sampling bias, as staff members with restrictive attitudes or a perceived or real lack of knowledge or confidence, are unlikely to volunteer to be interviewed. This makes it difficult to assess who within the team may need further support or training, because social desirability may be getting in the way of them admitting this.

The sample was also relatively small; however, data did appear to reach saturation within disciplines if not overall, and member checking was utilised to corroborate the validity of existing themes which were present across the data set rather a single interview.

A primary aim of the study was to ascertain how teams are balancing sexual safety with risk, however participants sometimes found it difficult to articulate this and would often speak in general terms of the barriers.

This study was service specific, leading to targeted recommendations for the Oxfordshire CLDT. Themes may therefore not be generalisable to other settings, although it is likely that there will be similar challenges faced by other ID services, and therefore some shared learning can likely be taken.

The current study did not integrate the views of service users themselves, however some dissonance between the two has been previously found (Grace et al., 2017), and further research into this may be a useful future direction.

4.6 Service Recommendations

Several service recommendations, such as upskilling and resources, are made in table five.

Table 5. *Service recommendations*

	Recommendation	**Response from Oxfordshire CLDT**
Training/upskilling	Staff may benefit from upskilling in balancing sexual rights and sexual safety. Few participants were clear on what exactly any training should contain, however it is likely that outlining what professionals can do when supporting service users in this area will increase confidence. It is recommended that this includes case example discussions and role plays, to facilitate open discussion between staff to further normalise considerations of sexual rights for service users and to	Psychology within the team agree that opportunities for modelling and role playing of conversations could be taken up more frequently, to increase level of comfort and confidence for staff in this area. The development of any formal training would depend on resource.

	Recommendation	Response from Oxfordshire CLDT
	practice broaching these topics. It is acknowledged that the burden of developing and delivering any internally based skills sessions would likely fall on psychology within the team and would be an increase in workload.	
Assessment	The CLDT currently offer a thorough and holistic core assessment to establish need. Enquiring about sex and intimate relationships is not part of this. It is recommended that this be added, to identify service users who may benefit from support in this area. Professionals are recommended to make it clear that they are a safe and appropriate person to raise this with. Further consultation with the team may be required to establish how to include this, and to consider staff's level of comfort.	This recommendation can be taken up, discussions within the team will need to take place to establish when and how during the assessment process it feels most appropriate to ask service users about intimate relationships (e.g., possibly when other carers/family members are not also present).
Risk formulation	Where circumstances are potentially risky, it is recommended that staff within the CLDT utilise a risk assessment framework document that can be shared with other services, clarifying scenarios and roles, to structure thinking and discussions. However, a standardised, 'one size fits all' approach is *not* recommended, and any risk assessment tool should be used alongside individual formulation.	The CLDT have recently removed a tool that relies on a rating system for risk and will encourage use of a complex needs document template instead, that exists outside of the NHS notes system and can be shared with wider services to structure conversations about risk or complexity within a case.
Resources	It is evident that the CLDT have access to numerous useful resources around this topic, including capacity assessment materials, easy read, and pictorial materials etc. It is recommended that these be collated (electronically, with reference to the location of resources which are physical only) and held in a shared and easily accessible format for all staff (e.g., a shared folder). It is recommended that this be continually updated, and staff periodically reminded of its location. This resource pack may also include a contact list of	An assistant psychologist has been tasked with creating and sharing this, and there are conversations taking place regarding physical resources being shared across localities rather than being kept in one place that is not easily accessible. As part of another, larger project, an organisational flow chart for when and how to report incidents to

	Recommendation	Response from Oxfordshire CLDT
	other relevant agencies (e.g., non-emergency police), and in what circumstances and at what stage it may be necessary to involve them.	the police will be created, and staff will be encouraged to use the incident report system more widely (e.g., for near misses) to better capture data.
Shared learning	Staff were clear about the usefulness of a space to discuss clinical dilemmas with the rest of the team and hear suggestions. It is recommended that this routinely include issues of sexual risk and safety, allowing staff the chance to bring issues they may not have previously thought to. In addition, positive outcomes may also be brought, as this may provide other staff with ideas and strategies not yet considered, relevant to their own cases. Where there is an appropriate professional to facilitate, it is recommended that this space act as a sex and relationships specific group supervision.	The team currently have frequent formulation sessions that are not well attended, and this is being considered. Going forward, facilitators will provide case studies so staff do not feel they are required to bring a piece of work. This space is facilitated by psychologists who will be able to offer group supervision.
The sex and relationships group	Part of the CLDT currently offer a sex and relationships psychoeducational group for individuals with an ID via referral. It is recommended that provision of this be prioritised across localities, and for the group to run consistently. Where possible, staff of various professionals may rotate into the group, to gain experience and confidence having conversations about sex and relationships with their service users. Staff of all disciplines may also use the session outlines to provide ad hoc 1:1 sessions where a group setting is not appropriate or practical.	Currently there is only provision for the psychoeducational group in one locality of the team and this is run by nursing. There is agreement that this could involve a wider variety of professionals, although there are overall workload burdens to consider. Conversations will begin with other localities as to the clinical justification why this is not being offered in some places.

4.7 Conclusion

This SIP has highlighted the complex job of professional's attempting to balance sexual rights with sexual safety in a community ID population. Participants felt their greatest strength was

empowering their service users and normalising a desire for intimate relationships. Barriers were identified, leading to several recommendations that may improve confidence and competence in this area.

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Theoretically Driven Research Project: The Impact of Relational Security on Professional Quality of Life for Staff on Forensic Inpatient Units, and the Role of Self-Compassion

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Abstract

Threat in all forms may be considered pervasive for staff working in forensic inpatient units, and there is a lack of research into relational elements of security in these environments. This can have negative consequences for patients, services, and staff, and safety is a primary objective in organisational policy. Burnout, compassion satisfaction, and secondary traumatic stress are components of professional quality of life, and previous literature shows that self-compassion positively impacts these components. The current study was a cross-sectional design, and 57 forensic inpatient staff of various disciplines completed the See Think Act scale (STA), the Self-Compassion Scale Short-Form (SCS-SF), and the Professional Quality of Life (ProQoL) scale. Results showed that relational security was significantly predictive of compassion satisfaction and secondary traumatic stress, but not burnout. Self-compassion was not found to be a moderator for any of the relationships. This has implications for interventions for staff and indicates directions for future research. The limitations are discussed.

Keywords: *forensic, relational security, compassion-focused therapy, self-compassion, burnout, compassion satisfaction, secondary traumatic stress*

5.1 Introduction

5.1.1 Background

5.1.1.1 Relational security

Violence from patients towards staff is commonly reported in National Health Service (NHS) settings (Ashton et al., 2018), particularly in inpatient psychiatric contexts (Kelly et al., 2014). Forensic mental health inpatient units house individuals with high acuity of complex and severe mental illness (e.g., bipolar affective disorder, schizophrenia) who may have had contact with the criminal justice system, be at risk of contact, and may have criminal and violent offence histories (Department of Health [DoH] & Ministry of Justice [MoJ], 2009; Newman et al., 2012; Haines et al., 2017; Verstegen et al., 2017). Types of violence observed in these settings towards staff and other service users include verbal aggression, threats of violence, and physical aggression, with much of this directed towards nurses specifically (Ireland et al., 2021). A literature review by Bowers et al., (2011) found that 79% of nurses had experienced violence at some point during their career, and 90% had reportedly been subject to verbal threats or aggression, suggesting that assault of some description remains a pervasive threat (Kelly et al., 2015).

Exposure to violence and abuse by patients has been found to lead to poorer staff wellbeing, mental health, performance, and satisfaction in the workplace, as well as increased staff turnover (Cramer et al., 2020; Kafle et al., 2022) and stress reactivity (Kelly et al., 2017). Extreme stress reactions such as Post-Traumatic Stress Disorder (PTSD) in the wake of being

exposed to violence and aggression (whether directly or as a witness) can be cumulative or vicarious in nature, resulting in damage to staff's psychological health (Cramer et al., 2020; Ireland et al., 2021). Van Leewen and Harte (2015) suggest that it is the threat of, rather than actual violence, that contributes the most to these outcomes. Physical consequences of being assaulted in the workplace, and the impact of subsequent sick leave on services, have also been reported (Newman et al., 2012).

Addressing issues of safety in secure forensic inpatient units tends to be highlighted as a primary objective in relevant organisational policies (NHS England & NHS Improvement, 2021). The subjective sense of one's physical, emotional, and interpersonal safety is thought to result from an interaction of individual and contextual factors, such as the safety climate and incident reporting culture (Haines et al., 2017). It seems that research interest has mainly focused on exploring the impact of the physical environment on moderating violent outcomes in healthcare settings (Haines et al., 2017). For instance, Haines et al., (2017) found that staff perceptions of safety on inpatient forensic wards were increased by changing elements of the physical setting such as brightness of lighting and space.

The NHS consider these physical and environmental elements to security (e.g., locks, fences, alarms), but clarify that these are in combination with other components, all necessary to maintain security in forensic healthcare settings. The other two are procedural (policies and procedures, e.g., restraint policy, reporting), and relational components (DoH, 2010). Relational security has been noted on serious incident reports as an important factor in safety on secure inpatient units, but the concept remains poorly constructed and investigated compared to procedural and physical security (Chester et al., 2017). According to the DoH, relational security is ‘’the knowledge and understanding we have of a patient, of ourselves,

and of the environment, and the transition of that information into appropriate responses and care'', these staff responses contribute to the overall safety of the unit and those within it. The definition specifies that relational security is not about just having a ''good relationship'' with patients, and that ''safe and effective relationships between staff and patients must be professional, boundaried, therapeutic, and purposeful'' (DoH, 2010, p. 4).

Chester et al., (2017) point out that difficulty has arisen in the research due to overlap of other phenomena, such as 'therapeutic relationships' and 'boundaries', which are related concepts, but lack the direct link to security. As such, relational security is complex to measure, and despite its relevance to secure services, there appear to be only two, relatively recent measures that aim to capture it. These are the Relational Security Explorer ([RSE], DoH, 2010), and the See Think Act Scale ([STA], Tighe & Gudjonsson, 2012), which has better internal consistency (Chester et al., 2017), and is the only one to have been validated in multiple countries (e.g., de Vries, Verkes & Bulten, 2022).

Perhaps due to this difficulty in conceptualisation and measurement, it is not clear from current research, whether a lack of relational security is also associated with professional quality of life in healthcare professionals, in the same way that physical elements have been shown to. It is important to ascertain whether there is an association with relational security and professional quality of life outcomes because it may feed into interventions for staff wellbeing.

5.1.1.2 Professional quality of life

Stamm (2010) proposed that professional quality of life is made up of three factors; burnout, compassion satisfaction, and secondary traumatic stress (Professional Quality of Life Scale

[ProQoL]). Maslach and Jackson (1981) described burnout as a state of emotional weariness that can occur in individuals working in roles that centre around the wellbeing of other people. Individuals can feel as if they are no longer able to attend to their clients and may develop negative feelings towards them (Maslach & Jackson, 1981). It stems from chronic exposure to emotional and interpersonal work stressors within a systemic context, and Maslach et al., (2001) posit three characteristic elements: exhaustion, cynicism or depersonalisation, and inefficacy.

Prolonged exposure to threat can activate the stress response system and contribute to burnout, and the healthcare profession is at particularly high risk (Schaufeli & Taris, 2014; De Hert, 2020). Burnout in forensic healthcare staff has been linked to PTSD symptoms and less emotional clarity, an element of the Trait Meta-Mood Scale of emotional intelligence (Salovey et al., 1995) that refers to the ability to identify and differentiate what one is feeling, which is necessary for deploying effective emotional regulation strategies and limiting distress (Jowsey et al., 2024). This can have negative individual consequences, including substance misuse, interpersonal difficulties, and suicidal ideation (De Hert, 2020; Nguyen et al., 2025), in addition to organisational consequences such as lower patient satisfaction, poorer care, and higher turnover (Leiter & Maslach, 2009; De Hert, 2020). Leiter and Maslach (2009) found burnout was predictive of intentions to leave the job in nurses, and that it mediated the impact of job demands. Emotional exhaustion and depersonalisation have been found to be particularly elevated in mental health workers, although they may be able to maintain a sense of personal efficacy and accomplishment (O'Connor et al., 2018).

Secondary traumatic stress is an indirect or vicarious response to being exposed to the trauma of others and can lead to intrusions, avoidance, and changes to cognition and reactivity

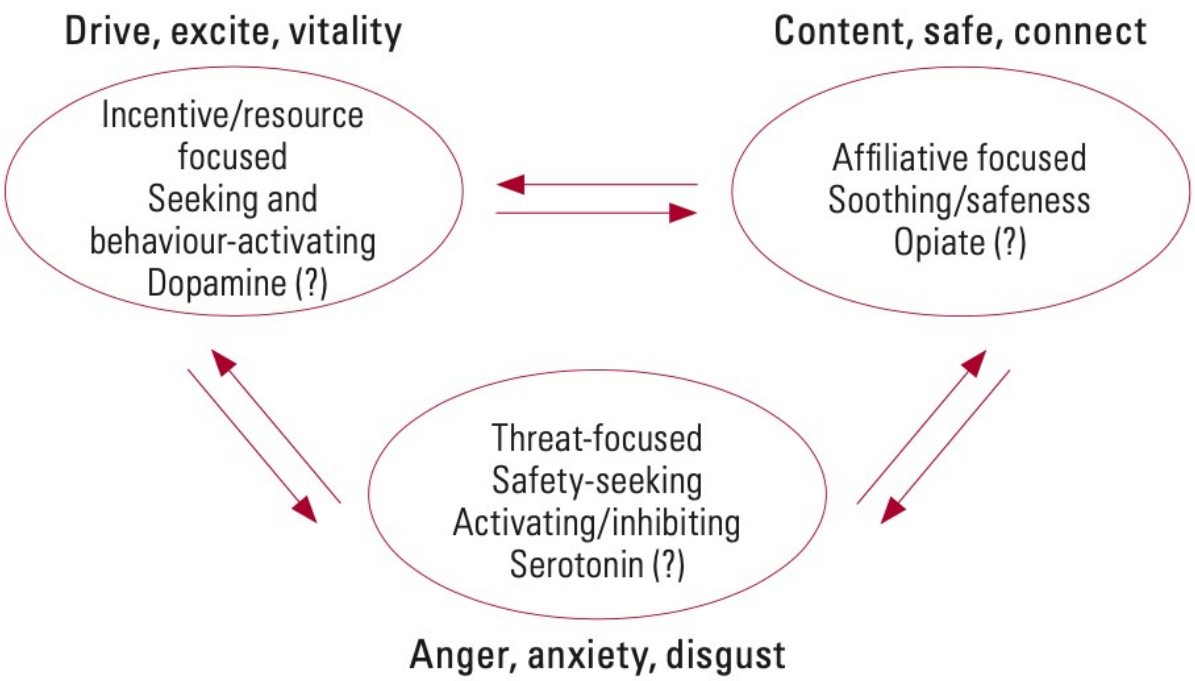
(Sprang et al., 2018). Compassion fatigue is defined as when empathic, caring individuals begin internalising the trauma around them leading to loss of compassion (Najjar et al., 2009). It has been observed in staff working in forensic inpatient environments and is thought to result in negative patient experiences and a poorer quality of care (Najjar et al., 2009; Lepore, 2024).

5.1.1.3 Self-compassion

Compassion is an attunement to the suffering of others and a desire to prevent or ease it (Leaviss & Uttley, 2014). Self-compassion refers to this process directed inward, when one is supportive towards the self in response to pain or suffering, whether in response to external challenges, or personal inadequacies, and this is linked to mental and physical well-being (Neff, 2003; Neff, 2022). Neff (2022) postulates that self-compassion requires turning towards the suffering, and being present with this discomfort, and that it should engender feelings of care and warmth, rather than judgement.

Compassion focused therapy ([CFT], Gilbert, 2009) originates from well-established neurophysiology research into the evolutionary threat detection and protection mechanism. The three systems that form the basis of CFT are soothe, drive, and threat. The model states that individuals typically switch between the three systems (figure 1), which are related to different emotions and neurochemical processes.

Figure 2. *The Three Systems of the CFT Model (Gilbert, 2005; cited in Gibert, 2009)*



Drive motivates achievement, while the threat system aims to protect, however this can be activated too quickly or when not needed. The soothe system helps to manage stress and bond with others and is associated with feelings of trust, safety, and contentment (Gilbert, 2009).

These systems are thought to be universal, and to influence cognition, affect, and behaviour, with an imbalance between them being linked to psychological distress (Moloney-Gibb et al., 2025). As a therapeutic approach, CFT aims to balance and better regulate these systems by promoting compassion. CFT has a growing evidence base to support its impact on increasing patient satisfaction (Strauss et al., 2016) and improving clinical outcomes, particularly for individuals who have high levels of self-criticism (Leaviss & Uttley, 2015), and CFT is also

increasingly being applied to trauma disorders and related symptomology (Harman & Lee, 2010). In such instances, trauma is understood as the product of an overactive threat system, inhibiting feelings of safety, and resulting in associated emotions such as anger and anxiety (Gilbert, 2014). Findings indicate that the perception of threat can be reduced by increasing the ability to activate the soothing system (Gilbert, 2014).

Individuals in an active state of threat are more likely to act in an 'avoid' response, i.e., fight-flight-freeze, than to 'approach' the threat, even for a potential reward (e.g., Weaver et al., 2020). In forensic inpatient environments, this may involve staff using their knowledge of a service user to de-escalate a situation, forming the basis of relational security. This requires activation of the soothing system and subsequent affiliative emotions, to respond in a nuanced way. Previous well-established research has shown that when under threat, this is difficult to do, as cognitive biases around the perception of cues and the likelihood of dangerous outcomes can be activated (Mathews, Mackintosh & Fulcher, 1997). Also, continued exposure to threat can reinforce heightened levels of threat processing, making it difficult and unfamiliar to activate alternatives such as the soothing system (Welford, 2010). Engaging relational responses is in line with current policy around using the least restrictive option ([MH3 Reducing Restrictive Practices within Adult Low and Medium Secure Services], NHS England, 2016), as this has been found to have a negative and re-traumatising effect on patients, as well as causing emotional distress and moral conflict within staff (Wong & Kahn, 2023).

Compassionate leadership has been found to be associated with higher job satisfaction and lower burnout (Trzeciak et al., 2017; Buonomo et al., 2022; Lains et al., 2023). There is also some evidence that mindful self-compassion is predictive of lower burnout in healthcare

professionals (Lyon & Galbraith, 2023), and better professional quality of life (Jung & Jung, 2025). Increased self-compassion, therefore, appears to lead to better activation of the soothing system and a less overactive threat system (Gilbert, 2009; 2014), and may act as a buffer to burnout in staff, leading to improved wellbeing in healthcare professionals (Leiter & Maslach, 2009; Porges, 2011; Prudenzi et al., 2022).

5.1.2 Aims of the Current Study

The current aim is to explore whether relational security has an impact on professional quality of life (burnout, compassion satisfaction, and secondary traumatic stress) in staff working on forensic inpatient units, and whether this is moderated by self-compassion.

Primary hypothesis

H^1: Higher relational security will predict lower burnout in forensic inpatient staff, when controlling for ward level of security and years of experience.

Secondary hypotheses

H^2: Higher relational security will predict higher compassion satisfaction in forensic inpatient staff, when controlling for ward level of security and years of experience.

H^3: High relational security will predict lower secondary traumatic stress in forensic inpatient staff, when controlling for ward level of security and years of experience.

H^4: These relationships will be moderated by self-compassion.

5.2 Methods

5.2.1 Ethical Approval

This study received ethical approval from the Health Research Authority (IRAS number: 342400; appendix J). The sponsor was Oxford Health NHS Foundation Trust ([OHFT] appendix K). Participants were provided with study information, gave informed consent, and had debrief information and support services made available to them (appendix L, M, and N). Participants remained anonymous throughout, and identifying data, including participant's workplace, was not collected to ensure this. Research recruitment has been found to be particularly difficult in forensic mental health professional samples (Pedersen et al., 2021).

5.2.2 Design

The study utilised a cross-sectional survey design, to establish any relationship between relational security and professional quality of life in forensic inpatient staff, and to explore the role of self-compassion.

5.2.3 Participants

Inclusion criteria was any adult working on a forensic inpatient unit in the UK, of any discipline. Exclusion criteria included staff only working in community services, or working on an inpatient ward that was not forensic. For individuals working across numerous wards, they were asked to fill the survey out with one ward in mind, for instance the one they work on the most or the one they worked on the most recently.

A priori power analysis on G*Power with 80% power, an alpha of .05, and a medium effect size indicated a minimum sample of 55 participants to test the primary hypothesis. A total of 57 participants were recruited, through email distribution and in-person recruitment at

relevant meetings within the main trust and a participant identification centre (PIC). The study poster and link were also shared online.

5.2.4 Public and Patient Involvement

Two experts by experience working in forensic inpatient services were consulted during all phases of the study.

5.2.5 Measures

5.2.5.1 Demographics

Demographic information was also collected. This encompassed participant gender, age group, ethnicity, professional discipline, years worked in forensic services, level of security at their place of work, gender of the patient group (i.e., male, female, mixed), and ward type (i.e., rehabilitation/low dependency, acute/high dependency, PICU, learning disability, other).

5.2.5.2 See Think Act scale

The See Think Act scale ([STA] Tighe & Gudjonsson, 2012; appendix O) is a self-report scale of 22-items which map onto four categories of the DoH construct. These are therapeutic risk management, pro-social team culture, boundaries, and patient focus. The STA has good convergent validity with related measures (p<.05 for the safety sections of the EssenCES scale [Schalast et al., 2008]), and good internal consistency ([Cronbach's alpha = .97] Tighe & Gudjonsson, 2012).

5.2.5.3 The Self-Compassion Scale

The Self-Compassion Scale – Short Form ([SCS-SF], Raes et al., 2011; appendix P) is a 12-item version of the original 26-item scale of self-compassion. It has sufficient correlation

with the longer scale (r=.97) and individual subscales were not going to be compared for analysis.

5.2.5.4 Professional Quality of Life scale

The ProQoL (Stamm, 2010; appendix Q) is a 30-item self-report measure for burnout, compassion satisfaction/fatigue, and secondary traumatic stress in professionals in a helping role (e.g., nurses, police officers). It has been found to have sufficient convergent validity, and norms specific to mental health workers have been established (Geoffrion et al., 2019; Hegarty & Buchanan, 2021). The three subscales will be used, to determine if relational security is having a different impact on the various areas of professional quality of life. It is not recommended to aggregate the three subscales into one overall score, nor to use any of them alone (Stamm, 2010).

5.2.6 Procedure

Participants were recruited at the main research site (OHFT), the PIC (Birmingham & Solihull Mental Health Foundation Trust), and nationally online, in order to maximise opportunities to obtain a sufficient sample size and optimise the variance in relational security scores.

Participants completed the measures anonymously online using Qualtrics, which also collected informed consent. Once completed, or if discontinued partway through, participants were directed to debrief information and signposted to relevant support resources. Participants were aware that once their data was submitted it could not be withdrawn as it would not be identifiable.

5.3 Results

5.3.1 Descriptive Statistics

Fifty-seven participants took part and demographic information can be seen in table's six and seven. Most participants were female (80.7%), White British (80.7%), and in the 30-39 age group (43.9%). Participants were primarily from psychology (43.9%) and nursing (36.8%). Most participants had 1-5 years of experience working in forensic services (45.6%) and worked on a low secure (52.6%) ward with male patients (80.7%). Most participants described their ward as being closest to a rehabilitation/low dependency (49.1%) need.

Due to the lack of large-scale study data, there are no current established norms or cut offs for the STA, however within the sample overall, relational security was rated similarly to previous literature such as Chester et al., (2017) (*M*=2.05, range=.93-2.79, α=.93). Compassion satisfaction for the sample fell in the average range, according to norms established by Stamm (2010) for helping professionals (*M*=37.23, range=16.00-49.00, α=.90), although cut-offs are not encouraged for diagnostic purposes. For burnout, the sample was also average (*M*=25.05, range=14.00-38.00, α=.84), as was secondary traumatic stress (*M*=22.53, range=12.00-39.00, α=.87). Self-compassion within the sample was moderate (Neff, 2011) (*M*=3.04, range=1.58-4.17, α=.89).

Table 6. *Demographic information*

Variable	**Frequency (%) *n=57***
Gender (%)	
Female	46 (80.7)
Male	11 (19.3)
Age (%)	

Variable	Frequency (%) *n=57*
18-29	22 (38.6)
30-39	25 (43.9)
40-49	3 (5.3)
50-59	6 (10.5)
60+	1 (1.8)
Ethnicity (%)	
Asian or Asian British	2 (3.5)
Black, African, Caribbean, or Black British	2 (3.5)
Mixed or multiple ethnic groups	2 (3.5)
White British	46 (80.7)
White Other	3 (5.3)
Other ethnic group	2 (3.5)

Table 7. *Job role information*

Variable	Frequency (%) *n=57*
Professional group (%)	
Nursing	21 (36.8)
Psychiatry	2 (3.5)
Psychology	25 (43.9)
Social Work	1 (1.8)
Support Worker	6 (10.5)
Other	2 (3.5)
Years experience in forensic mental health (%)	

Variable	Frequency (%) *n=57*
Less than one year	8 (14.0)
1-5 years	26 (45.6)
6-10 years	14 (24.6)
11 years and over	9 (15.8)
Level of ward security (%)	
Locked rehabilitation	2 (3.5)
Low secure	30 (52.6)
Medium secure	22 (38.6)
High secure	3 (5.3)
Gender of ward (%)	
Female	4 (7.0)
Male	46 (80.7)
Mixed	7 (12.3)
Type of ward (%)	
Rehabilitation/low dependency	28 (49.1)
Acute/high dependency	13 (22.8)
PICU	6 (10.5)
Learning disability	2 (3.5)
Other	9 (15.8)

5.3.2 Main Analysis

Burnout, compassion satisfaction, and secondary traumatic stress, were analysed in three hierarchical regressions, considered to be the most appropriate fit for the data and research aims.

The decision to control for ward level of security and years of experience in forensic services was contextually grounded. As higher security environments generally have stricter physical and procedural security elements, it may be more difficult to be relationally dynamic. It could also be considered that the risk of being involved in a traumatic incident is higher in such environments, leading to lower reporting's of relational security. Differences in relational security across medium secure, low secure, and rehabilitation wards has been previously found (Chester et al., 2017). Similarly, perceptions of how relationally secure a workplace is may be influenced by experience, which allows staff to be more familiar with the types of interpersonal dynamics present. By controlling for these, the relationship between relational security, self-compassion, and burnout, can be better isolated.

5.3.2.1 Normality

For each dependent variable (burnout, compassion satisfaction, and secondary traumatic stress), assumptions for a hierarchical regression were confirmed. Linearity was assessed by inspecting partial regression plots which displayed approximately linear relationships between each of the dependent variables, and the independent variable (relational security), and the moderator (self-compassion), indicating linearity could be assumed.

The control variables (ward security level and years of experience) were categorical, so were dummy-coded, and as such were not assessed for linearity. The lowest category for years of experience (less than one year) and security level (locked rehabilitation) were selected as the reference values, as they represented a common-sense baseline. Homoscedasticity was confirmed by inspecting scatterplots comparing standardised residuals and standardised predicted values. Durbin-Watson statistics of 2.277 (burnout), 2.245 (compassion fatigue),

and 1.870 (secondary traumatic stress) confirmed independence of residuals. All tolerance values were over .80 and VIF values below 1.3, therefore multicollinearity was not a concern. Histograms and normal probability (P-P) plots were used to assess normality of residuals, which was confirmed. Studentised deleted residuals, Cook's distance values, and centred leverage values suggested there were no significant outliers (confirmed by manual inspection of the data) or influential cases of concern. As such, no cases were removed.

5.3.2.2 Burnout regression

A hierarchical regression was conducted to determine whether relational security improved the prediction of burnout in forensic inpatient staff, above ward level of security and years of experience alone (table eight). The covariates did not significantly explain the variance in burnout scores, R^2=.002, adjusted R^2=-.035, F(2,54)=.041, p=.960.

Adding relational security and self-compassion to the model significantly improved it, explaining 58% more of the variance, R^2=.582, adjusted R^2-.550, ΔR^2=.578, F(4,52)=18.089, p<.001. In this model, self-compassion was a significant negative predictor of burnout (B=-6.732, SE=.977, β=-.681, p<.001). Relational security showed a negative association that was not significant (B=-2.656, SE=1.421, β=-.182, p=.067). Level of ward security and years of experience remained non-significant (p>.05).

The interaction term of relational security x self-compassion was not significant (B=1.218, SE=1.875, β=.066, p=.519), and adding it did not significantly improve the model, R^2=.585, adjusted R^2=.545, ΔR^2=-.35, F(5,51)=.422, p=.519, indicating that it is not moderating the relationship between relational security and burnout.

Table 8. *Hierarchical regression predicting burnout from relational safety and self-compassion, controlling for years of experience and ward security level*

Variable	**B**	**SE B**	**β**	**R^2**	**ΔR^2**	**ΔF**
Model 1				0.002	0.002	0.041
Years of experience	0.177	0.900	0.027			
Ward security level	-0.257	1.268	-0.028			
Model 2				0.582	0.580	36.084*
Years of experience	-0.533	0.605	-0.080			
Ward security level	-0.241	0.836	-0.026			
Relational security	-2.656	1.421	-0.182			
Self-compassion	-6.732	0.977	-0.681*			
Model 3				0.585	0.003	0.422
Years of experience	-0.594	0.616	-0.090			
Ward security level	-0.288	0.844	-0.031			
Relational security	-2.282	1.541	-0.157			
Self-compassion	-6.674	0.986	-0.675*			
Relational security x Self-compassion	1.218	1.875	0.066			

*Note. DV=Burnout, N=57, *p*<0.001*

5.3.3 Secondary Analyses

5.3.3.1 Compassion satisfaction regression

A hierarchical regression was run to determine whether relational security improved the prediction of compassion satisfaction in forensic inpatient staff, beyond ward level of security and years of experience (table nine). The control variables did not significantly explain the

variance in compassion satisfaction scores, R^2=.009, adjusted R^2=-.028, F(2,54)=.233, p=.793.

Entering relational security and self-compassion into the model significantly improved it (R^2=.495, adjusted R^2=.495, ΔR^2=.487, F[4,52]=12.749, p<.001, with the model explaining 49.5% of the variance in compassion satisfaction. In this model, self-compassion was a significant positive predictor of compassion satisfaction (B=5.373, SE=1.042, β=.560, p<.001), and relational security was also a significant positive predictor (B=3.701, SE=1.516, β=.262, p=.018). Years of experience and level of security were not significant predictors (p>.05).

In the third model, the interaction between relational security and self-compassion was added, but did not significantly improve the model by adding any variance (R^2=.495, adjusted R^2=.446, ΔR^2=.000, F[5,51]=10.006, p=.932). The interaction term was not significant, (B=.172, SE=2.008, β=.010, p=.932), suggesting that self-compassion does not moderate the relationship between relational security and self-compassion scores.

Table 9. *Hierarchical regression predicting compassion satisfaction from relational safety and self-compassion, controlling for years of experience and ward security level*

Variable	**B**	**SE B**	**β**	**R^2**	**ΔR^2**	**ΔF**
Model 1				0.009	0.009	0.233
Years of experience	0.099	0.871	0.015			
Ward security level	-0.822	1.226	-0.91			
Model 2				0.495	0.487	25.058**

Variable	B	SE B	β	R^2	ΔR^2	ΔF
Years of experience	0.643	0.646	0.100			
Ward security level	-0.858	0.892	-0.095			
Relational security	3.701	1.516	0.262*			
Self-compassion	5.373	1.042	0.560**			
Model 3				0.495	0.000	0.007
Years of experience	0.635	0.660	0.099			
Ward security level	-0.864	0.904	-0.096			
Relational security	3.754	1.650	0.265*			
Self-compassion	5.382	1.056	0.561**			
Relational security x Self-compassion	0.172	2.008	0.010			

*Note. DV=Compassion satisfaction, N=57, *p*<0.05, **p*<0.001*

5.3.3.2 Secondary traumatic stress regression

A final hierarchical regression was conducted to explore whether relational security improved the prediction of secondary traumatic stress in forensic inpatient staff, above ward level of security and years of experience alone (table ten). The covariates did not significantly explain the variance in secondary traumatic stress scores (R^2=.040, adjusted R^2=.004, F[2,54]=1.125, p=.332).

In model two, adding relational security and self-compassion significantly improved the model, now explaining 37% of the variance in secondary traumatic stress (R^2=.370, adjusted R^2=.322, ΔR^2=.330, F[4,52]=7.640, p<.001). Self-compassion was a significant negative predictor of secondary traumatic stress (B=-3.791, SE=1.311, β=-.351, p=.006), as was

relational security (*B*=-5.474, *SE*=1.909, *β*=-.343, *p*=.006). The covariates remained non-significant (*p*>.05).

By adding the interaction term into the third model, there was a small, non-significant improvement (R^2=.412, adjusted R^2=.355, ΔR^2=.042, *F*[5,51]=7.158, *p*=.061), explaining 41.2% of the variance. This indicates that self-compassion does not significantly moderate the relationship between relational security and secondary traumatic stress.

Table 10. *Hierarchical regression predicting secondary traumatic stress from relational safety and self-compassion, controlling for years of experience and ward security level*

Variable	**B**	**SE B**	**β**	**R^2**	**ΔR^2**	**ΔF**
Model 1				0.040	0.040	1.125
Years of experience	-1.224	0.966	-0.169			
Ward security level	1.042	1.360	0.102			
Model 2				0.370	0.330	13.628***
Years of experience	-1.568	0.813	-0.217			
Ward security level	1.110	1.123	0.109			
Relational security	-5.474	1.909	-0.343**			
Self-compassion	-3.791	1.311	-0.351**			
Model 3				0.412	0.042	3.663
Years of experience	-1.803	0.802	-0.249*			
Ward security level	0.933	1.099	0.091			
Relational security	-4.040	2.007	-0.253*			
Self-compassion	-3.568	1.284	-0.330**			

Variable	B	SE B	β	R^2	ΔR^2	ΔF
Relational security x Self-compassion	4.674	2.442	0.231			

*Note. DV=Secondary traumatic stress, N=57, *p*<0.05, ***p*<0.01, ****p*<0.001

A Holm-Bonferroni correction was applied for the three planned comparisons testing the predictive value of relational security on burnout (H^1), compassion satisfaction (H^2), and secondary traumatic stress (H^3), to control for Type I error. Holm-Bonferroni was chosen as it offers a balance between statistical power and error control, making it suitable for a small number of comparisons driven by a hypothesis (Holm, 1979; Field, 2018). The raw p-values for relational security in each model were ranked in ascending order and compared against alpha thresholds (α=.05) (appendix R). The effect of relational security remained statistically significant for compassion satisfaction and secondary traumatic stress, but not for burnout.

This indicates that the primary hypothesis, higher relational security will predict lower burnout in forensic inpatient staff, when controlling for ward level of security and years of experience, is not supported. However, H^2, that higher relational security will predict higher compassion satisfaction in forensic inpatient staff, when controlling for ward level of security and years of experience, and H^3, higher relational security will predict lower secondary traumatic stress in forensic inpatient staff, when controlling for ward level of security and years of experience, were both supported. H^4, that these relationships will be moderated by self-compassion, was not supported.

5.4 Discussion

To summarise, relational security was found to be significantly positively predictive of increased compassion satisfaction and significantly negatively predictive of secondary

traumatic stress, when controlling for the ward level of security and years of experience in forensics. Relational security was not found to be significantly predictive of burnout. None of these relationships were found to be moderated by self-compassion. As such, the hypotheses were partially supported.

Self-compassion was found to explain a significant amount of the variance in scores for burnout, compassion satisfaction, and secondary traumatic stress, supporting previous findings that it may increase the soothing system leading to a less overactive threat system (Galbert, 2009; 2014), and buffering burnout (Leiter & Maslach, 2009; Porges, 2011; Prudenzi et al., 2022).

This is also in line with findings by Jung and Jung (2025) that self-compassion is associated with better quality of life in healthcare professionals, and that mindful self-compassion is related to lower burnout (Lyon & Galbraith, 2023). Indeed, compassion focused staff support has been proposed as an intervention for the ‘cost of caring’ for staff in forensic services (Lucre & Taylor, 2020).

It may be that relational security equates to lower perceived threat, allowing activation of the soothing system, and that this is associated with higher compassion satisfaction and lower secondary traumatic stress. The non-significant result for burnout may indicate that this phenomenon is more impacted by other factors, such as workload demands already evidenced in the literature (Leiter & Maslach, 1999), meaning that it is less influenced by relational security. Interventions for burnout often focus on controlling manageable elements of work and regaining a sense of agency and autonomy (Razai et al., 2023). It may be that relational security practices do not feel in the control of individual staff members. Furthermore, the

non-significant result for self-compassion as a moderator may suggest that there are other confounding factors at play, or that it acts as a mediator rather than a moderator. Relational security may also be considered an interpersonal concept that has less effect on those that are intrapersonal, such as self-compassion.

5.4.1 Limitations

It is important to acknowledge the limited scope of this study. It was correlational in design, and it is therefore not possible to infer causality from the observed relationships, although the results suggest associations between them. Nonetheless, this study represents a first step in what is so far a relatively unexplored area, with limited empirical evidence.

In addition, this study involved a relatively small sample, and a larger one would allow for between-group comparisons to investigate setting-specific differences such as ward model approaches and culture. There may also have been a self-selection bias present, indicated by the high proportion of psychological professions taking part, as these staff likely have more time and willingness to respond, and may be more focused on relational and staff wellbeing issues as part of their role. Larger studies in general mental health inpatient environments offer insight into the demographics of staff in these settings, indicating that there are more females (64%) than males (36%) (Johnson et al., 2011). The same study indicated that psychologists made up 2% of staff, and ethnicity was reported as primarily White (75%). Comparable statistics have not been reported specifically for forensic settings, however it would seem that the sample of this study was likely not representative of the workforce overall.

Furthermore, significantly more participants began to fill out the measures than completed them, despite efforts being made to keep the participant burden as low as feasible. This

suggests there may have been more interest in this topic than indicated, but unknown barriers prevented some participants from fully taking part.

Similarly, individuals feeling particularly burnt out and compassion fatigued, may have been less likely to engage in research, and to want to reflect on this issue, as it may feel too distressing. This is problematic, as issues of professional quality of life may be most affecting staff such as nursing and support workers, meaning burnout, compassion satisfaction, and secondary traumatic stress are underestimated. Finally, individuals working in forensic settings may share the attitudes of similar professions (e.g., police and emergency services), where being stoic and emotionally in control is prized, and being open about mental health difficulties can be discouraged (e.g., Karaffa & Koch, 2015). This may cause them to struggle to recognise or report when they are feeling burnt out, leading to underreporting.

5.4.4 Clinical Implications

Given the results of this study and the literature that has come before it, it appears that self-compassion-based interventions and approaches may be useful in reducing burnout and increasing compassion satisfaction in forensic inpatient staff. A provision for this would be beneficial for patient care outcomes and cost-effective in the long run, as these variables have been shown to contribute to staff turnover and sickness.

This study suggests that in forensic settings, relational security is associated with more compassion satisfaction and less secondary traumatic stress and may, therefore, be an additionally useful element to address when considering staff's professional quality of life, and their sense of safety and threat in the workplace. It is important to note, however, that wider systemic factors such as the culture, team dynamics, and support offered, are also likely playing a role. These must be addressed also, and the difficulties in this work placed in their context, in order to avoid the problem being located solely within individuals and their sense of personal resilience.

5.4.3 Future Directions

Longitudinal designs and follow-up data would be a useful next step to establish patterns and changes in relational security over time, potentially pointing to causality. Experimental components would also assist in this, although there may be ethical considerations in manipulating threat and safety for participants. Furthermore, a qualitative component to any further research may add context and nuance to future investigations into relational security, such as what exactly staff mean when they use the term.

5.5 Conclusion

This study suggests that relational security is predictive of better professional quality of life and reduced stress in forensic inpatient staff. Burnout may be more related to systemic or workload related pressures than relational security. These findings partially support CFT models but suggest that relational security does not cushion all workplace quality of life outcomes. Intervention, training, and supervision may benefit from considering relational processes, not just self-compassion, to promote wellbeing and limit negative outcomes.

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Declaration of Interest Statement

None to declare.

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6. Executive Summary

Introduction

Violence towards staff is common in the NHS and can be more present in forensic environments due to the nature of the work. This can lead to poorer care outcomes for patients, and consequences for staff, including high turnover and mental health difficulties. There are three elements to security and safety for patients and staff in forensic inpatient environments: physical, procedural, and relational. Relational security has received perhaps the least attention, despite being frequently referenced in incident reporting. This may be due to difficulties in conceptualisation and measurement.

For individuals in a helping role such as healthcare, professional quality of life can be conceptualised in three elements: burnout, compassion satisfaction, and secondary traumatic stress. Burnout stems from work stressors and is a state of emotional tiredness that means professionals are less able to attend to the people they help, and they may develop negative feelings towards them. This can happen when staff are consistently exposed to threat, which activates their stress response system.

Compassion Focused Therapy (CFT) is an approach that attempts to balance three systems that are suggested as being present in everyone. These are drive, threat, and soothe. The drive system motivates us to achieve, while the threat system protects us from harm. The soothe system is necessary for bonding with others and managing stress. Promoting compassion can increase the activation of the soothe system and decrease overactivation of the threat system. There is research to support the idea that self-compassion can reduce burnout.

Research Questions

Because of this, this study aimed to explore the relationship between relational security and burnout, compassion satisfaction, and secondary traumatic stress, while controlling for the years of experience someone has worked in forensic services and the level of security on the ward they work on. It also aimed to determine if any of these relationships are moderated by self-compassion.

Methods

Adults aged 18 or over who worked on a forensic inpatient unit in the UK were eligible to take part. They could be of any professional discipline. 95 participants began to participate, however only 57 of those were eligible to be included, based on completing all of the necessary measures. Participants were recruited through Oxford Health NHS Foundation Trust, Birmingham and Solihull Mental Health Trust, and online platforms relevant to this population.

Participants completed a measure for relational security at their place of work, their professional quality of life, and their self-compassion. Most participants were White females working in a psychological profession.

Summary of Findings

The study found that relational security was not significantly associated with burnout but was significantly associated with higher compassion satisfaction and lower secondary traumatic stress. None of these relationships were moderated by self-compassion, although self-compassion was significantly associated with the three outcome variables on its own, in line with previous research.

Discussion and Limitations

The findings of this study partially supported the idea that relational security may be related to an overactive threat system. The relationship to burnout was not significant, possibly because burnout is more significantly affected by other factors.

One important limitation of this study is a sampling bias. Many people working in similar environments (e.g., police), have a culture of bravado, where they see value in carrying on in the face of threat and may struggle to acknowledge when things are difficult. In addition, staff feeling particularly burnt out may not have felt able or willing to take part in this research. Because of these factors, burnout scores may have been underrepresented.

7. Connecting Narrative

Undertaking research on the course has been a deeply challenging process, but one that has contributed significantly to my personal and professional development. I have had the opportunity to build on my existing interest in learning disability, autism, and forensics, and working clinically with these populations contributed to a passion for increasing the quantity and quality of research in these areas. Historically, these populations have been marginalised in society and research, and I have been struck by the impact this has on their safety, whether psychological, physical, relational, or institutional. The evolution of my three projects, although different in subject matter and methodology, represents my exploration of processes that promote and diminish safety for these groups.

Firstly, for my systematic review of the literature on the relationship between self-esteem and autism, this caused me to face issues around the external and internalised stigma that exists for autistic people, and the far-reaching impact this can have on their idea of their worth and value as a person. Having worked in several services with a high proportion of autistic clients, including children's and forensic services, I was anecdotally aware of both the positive and negative connotations that come with the current diagnostic system. Whilst it can provide validation and an explanation for autistic people's experiences of the world, it is also a label that can disregard these at the individual level. As I read and summarised the papers from the review, I was struck by how I and other clinicians may make a significant difference to the lives of our autistic clients by attending to their held beliefs about themselves, and by advocating for a respect of neurodivergent identities more widely.

My next project, the service improvement project, cemented my interest in matters of safety, specifically sexual safety, in a world where individuals with a learning disability are

frequently restricted under the premise of protection. This project aimed to consider how professionals balance this, and it was my first experience conducting research that had a tangible impact on the workings of a service. I had to confront my own ideas about a topic that can be difficult for professionals to talk about, whether due to discomfort, fear, or systemic inertia. In my role as a researcher instead of a clinician, I also tried to understand different points of view, some of which did not align with my own beliefs. This project has better prepared me for the ethical conundrums that can be present in this work, the importance of empowering people with a learning disability to be autonomous, and how easy it can be to inadvertently contribute to oppressive policies due to our own anxieties.

Finally, my theoretically driven research project was the most complex to conceptualise and complete and felt as if it brought my exploration of issues of safety to a natural close. In addition to looking at the safety and wellbeing of disempowered service users, I was now attending to people who offer care to these populations. Although not a new concept, it feels as if relational safety, compassion fatigue, burnout, and trauma for healthcare staff is only recently being given the research attention it deserves, and it continues to be overlooked practically in the workplace. It brought the difficulties of supporting complex populations to the forefront of my mind, and how developing appropriate interventions for staff and committing to relevant systemic changes can either exacerbate or mitigate this. I believe this area of interest is key to ensuring the prosperity of a safe and effective service going forward.

These projects, while different, have all encouraged me to think deeply about identity, safety, and power, concepts that I plan to carry forward into qualified work. My research journey has also allowed me to develop new skills and hone existing ones, specifically around reviewing and synthesising the evidence base, working within service dynamics to effect change, and

developing a methodology to effectively analyse the relationship between variables that have not been considered together before, and translate this into something meaningful. Looking forward, I hope to continue being involved in research, likely in an applied and co-produced way, while remaining curious, fostering safety, and asking the hard questions.

8. Acknowledgements

Firstly, I would like to thank all of my research supervisors for their support and expertise in shaping, carrying out, and writing up these projects. I also extend my thanks to everyone who assisted with recruitment and dissemination.

Thank you to my course tutors across the last three years, for their emotional support and the guidance that has kept me on track.

A huge thank you to the participants and experts by experience who have been involved in any of the projects.

To Charl and Sasha, for your unwavering kindness and support during all the highs and lows, and the laughs, I would not have been able to get through this without you. Your future clients are lucky to have you as their psychologists.

To my family, especially my mum, who never doubted for one second that I could do this, thank you.

Finally, to my wife, Lydia, I am immeasurably grateful for your encouragement, compassion, support, and love throughout this process. You have made it all worth it.

9. Appendices

Appendix A - Journal of Autism and Developmental Disorders Formatting Guidelines

Abstract

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

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

For life science journals only (when applicable)

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

Keywords

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

Statements and Declarations

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

- **Competing Interests:** Authors are required to disclose financial or non-financial interests that are directly or indirectly related to the work submitted for publication. Please refer to “Competing Interests and Funding” below for more information on how to complete this section.

Please see the relevant sections in the submission guidelines for further information as well as various examples of wording. Please revise/customize the sample statements according to your own needs.

Text

Text Formatting

Manuscripts should be submitted in Word.

- Use a normal, plain font (e.g., 10-point Times Roman) for text.

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

Headings

Please use no more than three levels of displayed headings.

Abbreviations

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

Footnotes

Footnotes can be used to give additional information, which may include the citation of a reference.

e included in the reference list. They should not consist solely of a reference citation, and they should never include the bibliographic details of a reference. They should also not contain any figures or tables.

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

Always use footnotes instead of endnotes.

Acknowledgments

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

Body

- The body of the manuscript should begin on a separate page. The manuscript page header (if used) and page number should appear in the upper right corner. Type the title of the paper centered at the top of the page, add a hard return, and then begin the text using the format noted above. The body should contain:

- Introduction (The introduction has no label.)
- Methods (Center the heading. Use un-centered subheadings such as: Participants, Materials, Procedure.)
- Results (Center the heading.)
- Discussion (Center the heading.)

Headings

Please use no more than three levels of displayed headings.

Level 1: Centered

Level 2: Centered Italicized

Level 3: Flush left, Italicized

Footnotes

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

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

Always use footnotes instead of endnotes. Type all content footnotes and copyright permission footnotes together, double-spaced, and numbered consecutively in the order they appear in the article. Indent the first line of each footnote 5-7 spaces. The number of the footnote should correspond to the number in the text. Superscript arabic numerals are used to indicate the text material being footnoted.

Terminology

- Please always use internationally accepted signs and symbols for units (SI units).

Scientific style

- Generic names of drugs and pesticides are preferred; if trade names are used, the generic name should be given at first mention.
- Please use the standard mathematical notation for formulae, symbols etc.:Italic for single letters that denote mathematical constants, variables, and unknown quantities

Roman/upright for numerals, operators, and punctuation, and commonly defined functions or abbreviations, e.g., cos, det, e or exp, lim, log, max, min, sin, tan, d (for derivative) Bold for vectors, tensors, and matrices.

References

Citation

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

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

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

Reference list

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

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

Journal names and book titles should be *italicized*.

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

- Journal article Grady, J. S., Her, M., Moreno, G., Perez, C., & Yelinek, J. (2019). Emotions in storybooks: A comparison of storybooks that represent ethnic and racial groups in the United States. *Psychology of Popular Media Culture, 8*(3), 207–217. https://doi.org/10.1037/ppm0000185
- Article by DOI Hong, I., Knox, S., Pryor, L., Mroz, T. M., Graham, J., Shields, M. F., & Reistetter, T. A. (2020). Is referral to home health rehabilitation following inpatient rehabilitation facility associated with 90-day hospital readmission for adult patients with stroke? *American Journal of Physical Medicine & Rehabilitation*. Advance online publication. https://doi.org/10.1097/PHM.0000000000001435
- Book Sapolsky, R. M. (2017). *Behave: The biology of humans at our best and worst*. Penguin Books.

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

Tables

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

Each table should be inserted on a separate page at the back of the manuscript in the order noted above. A call-out for the correct placement of each table should be included in brackets within the text immediately after the phrase in which it is first mentioned. Copyright permission footnotes for tables are typed as a table note.

Appendix B - Summary of Included Studies

Author(s) (year). Country	Study design	Focus	Sample	Self-esteem measure used	Key findings
Arwert, T. G., & Sizoo, B. B. (2020). The Netherlands	Cross-sectional, correlational	Suicide	75 autistic adults from a clinic providing psychiatric care. Mean age 35.89 (SD=12.96). 29 females and 46 males.	RSES (Dutch translation)	Self-esteem was significantly negatively associated with rumination and depression. Self-esteem was also related to the degree of suicidality but lost its contribution to the variance when controlling for depression. There was no gender effect for self-esteem and no significant effect for history of attempted suicide.
Chandler, R. J., Russell, A., & Maras, K. L. (2019). UK	Cross-sectional, between-groups correlational with an experimental element	Compliance	26 autistic adults (mean age 26.50 [SD=11.30]), 19 males and 7 females, from an NHS adult autism service, an 'autism summer school', and adverts on the National Autistic Society (NAS) website. 26 'typically developing' controls recruited through an undergraduate university, adverts, and word of mouth. Mean age 24.87 (SD=7.33), 16 males and 10 females.	RSES	Autistic participants reported significantly more early life victimisation, lower self-esteem, and greater compliance than non-autistic participants. Poorer self-esteem also significantly predicted self-reported compliance.
Cooper, K., Smith, L. G. E., & Russell, A. (2017). UK	Cross-sectional, between-groups correlational	Autistic identity	272 individuals who identified themselves as being autistic. 81% reported a formal diagnosis. Mean age 37.2 (SD=12.6), 47% women. Recruited through online forums for autistic people.	Adapted Private and Public Collective Self-Esteem Scale** RSES	There was a significant effect of sex on personal self-esteem, with lower rates in women. Those with a higher education also had significantly higher self-esteem.

Author(s) (year). Country	Study design	Focus	Sample	Self-esteem measure used	Key findings
			267 ‘typically developing’ participants from online university forums. Mean age 34.2 (SD=12.2), 53% females.		Autistic participants had significantly lower self-esteem when controlling for sex, sexuality, and education than non-autistic participants. Autism identification was positively associated with personal self-esteem and collective self-esteem.
Cooper, R., Cooper, K., Russell, A. J., & Smith, L. G. E. (2020). UK	Cross-sectional, correlational with a mixed-methods qualitative element	Autistic identity	140 autistic participants, aged 16 or over, recruited through online forums for autistic people and social media. 75% reported a formal autism diagnosis. Mean age 36 (SD=15), 51% female, 35% male, 13% preferred not to say. For the focus groups, 15 autistic participants were recruited from a university transition programme.	Adapted Private and Public Collective Self-Esteem Scale	There was a positive correlation between autism identification and autism collective self-esteem when controlling for gender and age. There was no significant effect for gender or age on collective self-esteem. The effect of valence of autism attributes on collective self-esteem was non-significant. There was a significant indirect relationship between valence of autism attributes and collective self-esteem through autism identification.
Corden, K., Brewer, R., & Cage, E. (2021). UK	Cross-sectional, correlational with a mixed methods qualitative element	Autistic identity	151 autistic individuals, mean age 31.26 (SD=10.23), 77.6% female, 19.7% male, 2.7% identified as non-binary or transgender. Recruited online through social	RSES	Wellbeing, autistic characteristics, gender, and recency and age of diagnosis, explained a significant amount of the variance in self-esteem.

Author(s) (year). Country	Study design	Focus	Sample	Self-esteem measure used	Key findings
			media and autism organisations and groups.		This was significantly increased when adding the disability identity subscales. Lower exclusion and dissatisfaction, and higher wellbeing significantly predicted higher self-esteem.
Ferenc, K., Platos, M., Byrka, K., & Krol, M. E. (2022). Poland	Cross-sectional, correlational	Autistic identity	109 autistic participants from autism groups and websites. 93% scored above cut-off on AQ-10. Mean age 30.01 (SD=8.27), 76.1% female, 23.9% male.	MSEI***	Perceiving oneself as more similar to 'typical' members of the autism community was predictive of higher psychological distress and lower self-esteem. Those who perceived it as closer to a neurodiversity than a disorder had higher self-esteem. Later diagnosis also significantly predicted lower self-esteem.
Longhurst, P., Todd, J., Aspell, J. E., & Swami, V. (2024). UK	Cross-sectional, correlational with a mixed methods qualitative element	Body image	550 autistic individuals though social media, 71.8% with a formal diagnosis and 28.2% in the process of getting one. 281 female and 269 were male. Mean age 33.07 (SD=10.07).	RSES	Body appreciation scores were strongly positively correlated with self-esteem, wellbeing, and psychological quality of life.
Marion, A., Bowman, K., Thomas, G., & Harrison, A. J. (2023). US	Cross-sectional, correlational	Stigma	45 autistic adults, 23 male, 21 female, 1 gender not reported. Mean age 25.12 (SD=9.50). Recruited through email lists, online adverts, and fliers.	Adapted RSES	Lower self-esteem was significantly correlated with greater reported disclosure stigma, but not significantly associated with discriminative stigma

Author(s) (year). Country	Study design	Focus	Sample	Self-esteem measure used	Key findings
McDonald, T. A. M. (2017). UK	Cross-sectional, correlational	Autistic identity	1139 autistic participants, 43.7% male and 59.1% female. Mean age for males 32.01 (13.58) and 35.09 (SD=12.40) for the females. Recruited through autism self-advocacy and support groups.	RSES	The ASIS showed good discriminative and criterion validity with other measures.
Nguyen, W., Ownsworth, C., Nicol, D., & Zimmerman, D. (2020). Australia	Cross-sectional, between-groups correlational	Self-esteem	71 autistic adults, mean age 37.82 (SD=14.42), 56% males and 44% females. Recruited from autism websites and services. 65 ‘typically developing’ controls recruited online and from a university, matched on age, education, and sex.	RSES	Autism characteristics were negatively associated with self-esteem. Greater acceptance and perceived benefits, and lower helplessness were significantly associated with higher self-esteem. Perceived social support was significantly positively associated with global self-concept and self-esteem. Autism characteristics and sex significantly contributed to the variance in self-esteem, and this increased when autism self-appraisal and perceived social support were entered into the model. Greater self-perceived giftedness, invulnerability, and power, were independently associated with higher global self-esteem, even when controlling for autism

Author(s) (year). Country	Study design	Focus	Sample	Self-esteem measure used	Key findings
					characteristics.
Pyszkowska, A., Nowacki, A., & Celban, J. (2025). Poland	Cross-sectional, correlational	Maladaptive daydreaming	293 participants, 139 with ADHD, 74 autistic, 80 with both. Mean age 32.88 (SD=8.43). 79.14% female in ADHD group, 68.75% female in AuDHD group. Recruited online through societies for autistic people or people with ADHD, and psychiatric centres.	SCLS-R**** (Polish translation)	Self-esteem was a significant negative predictor for maladaptive daydreaming in the autistic group. The ADHD group had higher self-esteem scores overall than the autism and AuDHD groups.
Soffer, M., & Argaman-Danos, S. (2021). Israel	Cross-sectional, correlational	Self-labelling	89 autistic adults. 51 male, 35 female, 3 unreported. Mean age 28.4 (SD=6.9). Recruited through service providers, academic institutions, and social media.	RSES (Hebrew translation)	There was no significant difference in self-esteem for individuals who self-labelled as having Asperger's compared to ASD. The scores for self-esteem were generally high. Adding self-labelling as a mediator to a model examining the association between stigma towards autism and self-esteem did not change the fit, rather the negative correlation between perceived public stigma and self-esteem was direct.
Triantafyllopoulou, P., Clark-Huges, C., & Langdon, P. E. (2022). UK	Cross-sectional, correlational	Cyber-bullying	78 autistic participants, 37.2% male, 55.1% female, 7.7% preferred not to say. Mean age 29.3 (SD=9.7). Recruited online through relevant autism sites and forums.	RSES	Self-esteem was positively correlated with the number of online friends and seeing oneself as part of an online community. There was a negative relationship between self-esteem and cyber-

Author(s) (year). Country	Study design	Focus	Sample	Self-esteem measure used	Key findings
					bullying victimisation. Self-esteem was a significant predictor of cyber-bullying victimisation.
Tsermentseli, S. (2022). UK	Cross-sectional, between-groups correlational	Social support	57 autistic adults, 19 females. Mean age 31.30 (SD=8.14), from a university and specialist employment support agency 60 ‘typically developing’ controls, 28 females, mean age 29.62 (SD=7.15).	RSES	Autistic participants reported significantly lower self-esteem than controls. Global self-esteem was found to moderate the association between social support and life satisfaction. Self-esteem was found to be a significant predictor of life satisfaction in autistic adults.
Walker, L. (2023). US	Cross-sectional, correlational, with between group comparisons where sample size allowed	Autistic identity	135 autistic adults. 82 female, 19 male, 24 non-binary, 8 other. Mean age 42.2 (SD=13.4). Recruited through online adverts and social media.	RSES	Strong identification with a pathology paradigm of autism was significantly negatively correlated with self-esteem. There was no significant correlation between strength of identification with a neurodiversity paradigm and self-esteem.
Zhuang, S., Bougoure, M., Leong, D. J., Dean, L., Reddrop, S., Naragon-Gainey, K., Maybery, M., Weiting Tan, D., & Magiati, I. (2024). Australia	Cross-sectional, correlational	Camouflaging	225 autistic adults, 137 female, 64 male, 21 other, and 3 preferred not to say. Mean age 35.5 (SD=11.8). Recruited through online adverts and social media.	RSES	Higher self-esteem was associated with greater camouflaging. Autistic adults who perceived greater autism stigma reported lower self-esteem and reduced camouflaging.

Author(s) (year). Country	Study design	Focus	Sample	Self-esteem measure used	Key findings
Zimmerman, D., Ownsworth, T., O'Donovan, A., Roberts, J., & Gulio, M. J. (2017). Australia	Cross-sectional, correlational	Executive function	42 autistic adults through support services, clinics, and online forums. 64.3% male, mean age 34.02 (SD=12.42).	RSES	There was a significant negative correlation between matrix reasoning and self-esteem when controlling for age, gender, and years of education. Self-esteem was not significantly associated with anxiety. Stronger non-verbal reasoning and conceptual flexibility were related to poorer self-esteem.

* *Rosenberg Self-Esteem Scale (Rosenberg, 1965)*
** *Private and Public Collective Self-Esteem Scale (Luhtanen & Crocker, 1992)*
*** *Multidimensional Self-Esteem Inventory (O'Brien & Epstein, 1998)*
**** *Self-Competence/Self-Liking Scale – Revised (Tafarodi & Swann, 1995)*

Appendix C - QualSyst (Kmet et al., 2004) Ratings for Included Studies

	1. Question or objective sufficiently described? (Yes = 2/Partial = 1/No = 0)	2. Design evident and appropriate to answer study question? (Yes = 2/Partial = 1/No = 0)	3. Method of subject selection (and comparison group selection, if applicable) is described and appropriate (Yes = 2/Partial = 1/No = 0)/NA)	4. Subject (and comparison group if applicable) characteristics, variables, information sufficiently described? (Yes = 2/Partial = 1/No = 0)	5. If random allocation to treatment group was possible, is it described? (Yes = 2/Partial = 1/No = 0/ NA)
Arwert, T. G., & Sizoo, B. B. (2020). The Netherlands	2	2	2	2	NA
Chandler, R. J., Russell, A., & Maras, K. L. (2019). UK	2	2	2	1	NA
Cooper, K., Smith, L. G. E., & Russell, A. (2017). UK	2	2	1	2	NA
Cooper, R., Cooper, K., Russell, A. J., & Smith, L. G. E. (2020). UK	2	2	1	2	NA
Corden, K., Brewer, R., & Cage, E. (2021). UK	2	2	2	2	NA
Ferenc, K., Platos, M., Byrka, K., & Krol, M. E. (2022). Poland	2	2	2	2	NA
Longhurst, P., Todd, J., Aspell, J. E., & Swami, V. (2024). UK	2	2	1	2	NA
Marion, A., Bowman, K., Thomas, G., & Harrison, A. J. (2023). US	2	2	2	2	NA
McDonald, T. A. M.	2	1	1	2	NA

	1. Question or objective sufficiently described? (Yes = 2/Partial = 1/No = 0)	2. Design evident and appropriate to answer study question? (Yes = 2/Partial = 1/No = 0)	3. Method of subject selection (and comparison group selection, if applicable) is described and appropriate (Yes = 2/Partial = 1/No = 0)/NA)	4. Subject (and comparison group if applicable) characteristics, variables, information sufficiently described? (Yes = 2/Partial = 1/No = 0)	5. If random allocation to treatment group was possible, is it described? (Yes = 2/Partial = 1/No = 0/ NA)
(2017). UK					
Nguyen, W., Ownsworth, C., Nicol, D., & Zimmerman, D. (2020). Australia	2	1	2	2	NA
Pyszkowska, A., Nowacki, A., & Celban, J. (2025). Poland	2	2	2	2	NA
Soffer, M., & Argaman-Danos, S. (2021). Israel	2	1	1	1	NA
Triantafyllopoulou, P., Clark-Huges, C., & Langdon, P. E. (2022). UK	2	1	1	1	NA
Tsermentseli, S. (2022). UK	2	2	2	2	NA
Walker, L. (2023). US	2	2	1	2	NA
Zhuang, S., Bougoure, M., Leong, D. J., Dean, L., Reddrop, S., Naragon-Gainey, K., Maybery, M., Weiting	2	2	2	2	NA

	1. Question or objective sufficiently described? (Yes = 2/Partial = 1/No = 0)	2. Design evident and appropriate to answer study question? (Yes = 2/Partial = 1/No = 0)	3. Method of subject selection (and comparison group selection, if applicable) is described and appropriate (Yes = 2/Partial = 1/No = 0)/NA)	4. Subject (and comparison group if applicable) characteristics, variables, information sufficiently described? (Yes = 2/Partial = 1/No = 0)	5. If random allocation to treatment group was possible, is it described? (Yes = 2/Partial = 1/No = 0/ NA)
Tan, D., & Magiati, I. (2024). Australia					
Zimmerman, D., Ownsworth, T., O'Donovan, A., Roberts, J., & Gulio, M. J. (2017). Australia	2	2	2	1	NA

	6. If interventional and blinding of investigators was possible, is it reported? (Yes = 2/Partial = 1/No = 0/NA)	7. If interventional and blinding of subjects to intervention was possible, is it reported? (Yes = 2/Partial = 1/No = 0/NA)	8. Outcome and (if applicable) exposure measure(s) well defined and robust to measurement or misclassification bias? Means of assessment reported? (Yes = 2/Partial = 1/No = 0/NA)	9. Sample size appropriate? (Yes = 2/Partial = 1/No = 0/ NA)	10. Analysis desc and appropriate? (2/Partial = 1/No = 0/NA)
Arwert, T. G., & Sizoo, B. B. (2020). The Netherlands	NA	NA	2	1	
Chandler, R. J., Russell, A., & Maras, K. L. (2019). UK	NA	NA	2	1	
Cooper, K., Smith, L. G. E., & Russell, A. (2017). UK	NA	NA	2	2	

	6. If interventional and blinding of investigators was possible, is it reported? (Yes = 2/Partial = 1/No = 0/NA)	7. If interventional and blinding of subjects to intervention was possible, is it reported? (Yes = 2/Partial = 1/No = 0/NA)	8. Outcome and (if applicable) exposure measure(s) well defined and robust to measurement or misclassification bias? Means of assessment reported? (Yes = 2/Partial = 1/No = 0/NA)	9. Sample size appropriate? (Yes = 2/Partial = 1/No = 0/ NA)	10. Analysis desc and appropriate? (2/Partial = 1/No = 0/NA)
Cooper, R., Cooper, K., Russell, A. J., & Smith, L. G. E. (2020). UK	NA	NA	2	1	
Corden, K., Brewer, R., & Cage, E. (2021). UK	NA	NA	2	1	
Ferenc, K., Platos, M., Byrka, K., & Krol, M. E. (2022). Poland	NA	NA	2	1	
Longhurst, P., Todd, J., Aspell, J. E., & Swami, V. (2024). UK	NA	NA	2	2	
Marion, A., Bowman, K., Thomas, G., & Harrison, A. J. (2023). US	NA	NA	2	1	
McDonald, T. A. M. (2017). UK	NA	NA	2	2	
Nguyen, W., Ownsworth, C., Nicol, D., & Zimmerman, D. (2020). Australia	NA	NA	2	1	
Pyszkowska, A., Nowacki, A., & Celban, J. (2025). Poland	NA	NA	2	1	
Soffer, M., & Argaman-	NA	NA	2	1	

	6. If interventional and blinding of investigators was possible, is it reported? (Yes = 2/Partial = 1/No = 0/NA)	7. If interventional and blinding of subjects to intervention was possible, is it reported? (Yes = 2/Partial = 1/No = 0/NA)	8. Outcome and (if applicable) exposure measure(s) well defined and robust to measurement or misclassification bias? Means of assessment reported? (Yes = 2/Partial = 1/No = 0/NA)	9. Sample size appropriate? (Yes = 2/Partial = 1/No = 0/ NA)	10. Analysis desc and appropriate? (2/Partial = 1/No = 0/NA)
Danos, S. (2021). Israel					
Triantafyllopoulou, P., Clark-Huges, C., & Langdon, P. E. (2022). UK	NA	NA	2	1	
Tsermentseli, S. (2022). UK	NA	NA	2	1	
Walker, L. (2023). US	NA	NA	2	1	
Zhuang, S., Bougoure, M., Leong, D. J., Dean, L., Reddrop, S., Naragon-Gainey, K., Maybery, M., Weiting Tan, D., & Magiati, I. (2024). Australia	NA	NA	2	1	
Zimmerman, D., Ownsworth, T., O'Donovan, A., Roberts, J., & Gulio, M. J. (2017). Australia	NA	NA	2	1	

	11. Some estimate of variance (e.g., confidence intervals, standard errors) is reported for the main results/outcomes (Yes = 2/Partial = 1/No = 0/NA)	12. Controlled for confounding? (Yes = 2/Partial = 1/No = 0/NA)	13. Results reported in sufficient detail? (Yes = 2/Partial = 1/No = 0)	14. Do the results support the conclusions? (Yes = 2/Partial = 1/No = 0)	**TOTAL SUM**	**TOTAL POSSIBLE SUM**	**SUMMARY SCORE**	**QUALITY RAT**
Arwert, T. G., & Sizoo, B. B. (2020). The Netherlands	2	2	2	2	21	22	0.95	
Chandler, R. J., Russell, A., & Maras, K. L. (2019). UK	2	2	2	2	20	22	0.91	
Cooper, K., Smith, L. G. E., & Russell, A. (2017). UK	2	2	2	2	21	22	0.95	
Cooper, R., Cooper, K., Russell, A. J., & Smith, L. G. E. (2020). UK	2	2	2	2	20	22	0.91	
Corden, K., Brewer, R., & Cage, E. (2021). UK	2	2	2	2	21	22	0.95	
Ferenc, K., Platos, M., Byrka, K., & Krol, M. E. (2022). Poland	2	2	1	2	20	22	0.91	
Longhurst, P., Todd, J., Aspell, J. E., & Swami, V. (2024). UK	2	1	2	2	20	22	0.91	
Marion, A., Bowman,	1	1	2	2	19	22	0.84	

	11. Some estimate of variance (e.g., confidence intervals, standard errors) is reported for the main results/outcomes (Yes = 2/Partial = 1/No = 0/NA)	12. Controlled for confounding? (Yes = 2/Partial = 1/No = 0/NA)	13. Results reported in sufficient detail? (Yes = 2/Partial = 1/No = 0)	14. Do the results support the conclusions? (Yes = 2/Partial = 1/No = 0)	**TOTAL SUM**	**TOTAL POSSIBLE SUM**	**SUMMARY SCORE**	**QUALITY RAT**
K., Thomas, G., & Harrison, A. J. (2023). US								
McDonald, T. A. M. (2017). UK	2	NA	2	2	18	20	0.90	
Nguyen, W., Ownsworth, C., Nicol, D., & Zimmerman, D. (2020). Australia	2	2	2	2	20	22	0.91	
Pyszkowska, A., Nowacki, A., & Celban, J. (2025). Poland	2	2	2	2	21	22	0.95	
Soffer, M., & Argaman-Danos, S. (2021). Israel	0	1	2	2	15	22	0.68	**Mo**
Triantafyllopoulou, P., Clark-Huges, C., & Langdon, P. E. (2022). UK	2	1	2	2	17	22	0.77	
Tsermentseli, S. (2022). UK	2	2	2	2	21	22	0.95	

	11. Some estimate of variance (e.g., confidence intervals, standard errors) is reported for the main results/outcomes (Yes = 2/Partial = 1/No = 0/NA)	12. Controlled for confounding? (Yes = 2/Partial = 1/No = 0/NA)	13. Results reported in sufficient detail? (Yes = 2/Partial = 1/No = 0)	14. Do the results support the conclusions? (Yes = 2/Partial = 1/No = 0)	**TOTAL SUM**	**TOTAL POSSIBLE SUM**	**SUMMARY SCORE**	**QUALITY RAT**
Walker, L. (2023). US	2	1	2	2	19	22	0.86	
Zhuang, S., Bougoure, M., Leong, D. J., Dean, L., Reddrop, S., Naragon-Gainey, K., Maybery, M., Weiting Tan, D., & Magiati, I. (2024). Australia	2	1	1	2	20	22	0.86	
Zimmerman, D., Ownsworth, T., O'Donovan, A., Roberts, J., & Gulio, M. J. (2017). Australia	2	2	2	2	20	22	0.91	

Appendix D - British Journal of Learning Disabilities Formatting Guidelines

Title page

The title page should contain:
i. A short informative title that contains the major key words. The title should not contain abbreviations (see Wiley's best practice SEO tips);
ii. A short running title of less than 40 characters;
iii. The full names of the authors;
iv. The author's institutional affiliations where the work was conducted, with a footnote for the author's present address if different from where the work was conducted;
v. Acknowledgments.

Abstract and Accessible Summary

Papers should include a structured abstract (maximum 200 words) incorporating the following headings: Background, Methods, Findings, Conclusions. These should outline the questions investigated, the design, essential findings and main conclusions of the study. As well as an abstract, authors must include an easy-to-read summary of their papers. This was introduced in 2005, and was done so in the spirit of making research findings more accessible to people with learning disabilities. The editorial board also believe that this will make 'scanning' the Journal contents easier for all readers. Authors are required to:

- Summarise the content of their paper using bullet points (4 or 5 at most),
- Express their ideas in this summary using straightforward language, and
- State simply why the research is important, and should matter to people with learning disabilities.

Authorship

Please refer to the journal's authorship policy the Editorial Policies and Ethical Considerations section for details on eligibility for author listing.

Acknowledgments

Contributions from anyone who does not meet the criteria for authorship should be listed, with permission from the contributor, in an Acknowledgments section. Financial and material support should also be mentioned. Thanks to anonymous reviewers are not appropriate.

Conflict of Interest Statement

Authors will be asked to provide a conflict of interest statement during the submission process. For details on what to include in this section, see the section 'Conflict of Interest' in the Editorial Policies and Ethical Considerations section below. Submitting authors should ensure they liaise with all co-authors to confirm agreement with the final statement.

Main Text File

As papers are double-blind peer reviewed the main text file should not include any information that might identify the authors.

Manuscripts can be uploaded either as a single document (containing the main text, tables and figures), or with figures and tables provided as separate files. Should your manuscript reach revision stage, figures and tables must be provided as separate files. The main manuscript file can be submitted in Microsoft Word (.doc or .docx).

Your main document file should include:

- A short informative title containing the major key words. The title should not contain abbreviations
- The full names of the authors with institutional affiliations where the work was conducted, with a footnote for the author's present address if different from where the work was conducted;
- Acknowledgments;
- Abstract structured (Background, Methods, Findings, Conclusions)
- Keywords;
- Main body;
- References;
- Tables (each table complete with title and footnotes);
- Figures: Figure legends must be added beneath each individual image during upload AND as a complete list in the text.

Tables

Tables should be self-contained and complement, not duplicate, information contained in the text. They should be supplied as editable files, not pasted as images. Legends should be concise but comprehensive – the table, legend, and footnotes must be understandable without reference to the text. All abbreviations must be defined in footnotes. Footnote symbols: †, ‡, §, ¶, should be used (in that order) and *, **, *** should be reserved for P-values. Statistical measures such as SD or SEM should be identified in the headings.

Figure Legends

Legends should be concise but comprehensive – the figure and its legend must be understandable without reference to the text. Include definitions of any symbols used and define/explain all abbreviations and units of measurement.

Figures

Although authors are encouraged to send the highest-quality figures possible, for peer-review purposes, a wide variety of formats, sizes, and resolutions are accepted.

Click here for the basic figure requirements for figures submitted with manuscripts for initial peer review, as well as the more detailed post-acceptance figure requirements.

Color Figures. Figures submitted in color may be reproduced in colour free of charge. Please note, however, that it is preferable that line figures (e.g. graphs and charts) are supplied in black and white so that they are legible if printed by a reader in black and white.

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[dataset] Authors; Year; Dataset title; Data repository or archive; Version (if any); Persistent identifier (e.g. DOI)

References

This journal uses the *Publication Manual of the American Psychological Association* (6th edition) reference style; as the journal offers Free Format submission, however, this is for information only and you do not need to format the references in your article. This will instead be taken care of by the typesetter.

Additional Files

Appendices

Appendices will be published after the references. For submission they should be supplied as separate files but referred to in the text.

Appendix E - Interview Schedule

Introduction

Defining the terms

Sexual safety for this project means keeping service users with a learning disability safe from sexual risk that may be posed towards them *from others,* in addition to any risk they may pose *to others.* This may be in the form of a sexual offence, but also behaviours that are not criminalised, but are risky because of a lack of understanding or capacity.

Sexual rights for the project means the legal and ethical right for individuals with a learning disability to explore their sexuality, as people without a learning disability do. This is done through exploration and engagement in safe, consenting, and developmentally appropriate behaviours related to sexual expression.

We are interested in how professionals balance these two things.

What this project is not:

- A test of people's knowledge on these topics (more a focus on how you use your skills in your work to navigate this tricky area, and importantly, what suggestions you might have around what is needed to help you do this)
- Around specific clinical scenarios or service users
- Providing guidelines around capacity
- Advising on legal standpoints

Open questions

1. Tell me a bit about you and how you came to work in LD services?
2. What does sexual safety mean in your work?
3. Why do you think this is important (or not important based on their response)?

4. Can you talk a bit about how you navigate keeping service users safe in this way, with respecting their right to expressing themselves sexually and fulfilling their needs?
5. Are there any barriers to this?
6. Are there any considerations you particularly make/think about when supporting your service users in this way?

   (prompt: can you name three things you do when supporting service users in expressing their sexual rights while keeping them safe?)
7. How do you navigate these?
8. On this topic, what do you think the service currently does well?
9. Are there any areas where you think there could be improvements?
10. Is there anything specific that you think would be helpful in being able to maintain this balance for your service users?

Incident data

1. Does this fit with your experience?
2. Anything about this that surprises you?
3. Anything else you would like to mention today?

Appendix F - Table of Themes, Codes, and Quotes

Themes	Subthemes	Codes	Example quotes
1. Communication	Need for education	Sex ed. for PWLD, their families & other services	*'they've not had that opportunity or that education. And I don't think schools give that level of education'*
			'education is really important to help other people understand, as well as keeping our guys safe and equipping them with the knowledge'
		Providing consultation	*'bridging the gap between us and sexual health services and gynaecology as well to kind of increase their understanding too'*
			'several of us have had dealings with GP's of kind of trying to promote that sort of side of things'
		Language and non-verbal	*'it might depend on maybe someone's ability to express himself vocally'*
			'the right words for the conversation'
	Fighting the good fight	Normalising	*'we're making it normal and healthy and kind of appropriate for people. And I think that's quite unique.'*
			'I think that's a really positive thing from our perspective that we're having these conversations and normalising things'
		Empowering/advocacy	*'making sure the person's always involved in their care'*
		Higher standards for PWLD	*'Letting people know their rights and how to keep themselves safe'*
			'You know, if she didn't have the LD and she was doing that…'
			'actually she is a young woman, she has needs. You can't protect her at every stage of her life. And she is fully entitled to make these decisions because she does know what she's doing and she understands the consequences'
	Barriers	Discrimination & double stigma	*'there is a chance that maybe there's a stigma or discomfort, an assumption being held in the team'*
			'we've moved on hugely since everyone had to be in residential homes and hidden away from the public. But we've not moved on to mainstreaming properly and something that's practical, right?'
		Input of families	*'if I was living with my parents, they probably wouldn't be facilitating me or helping me to have sexual relationships like that's normal that you don't want*

Themes	Subthemes	Codes	Example quotes
		Service constraints	*to think about your children as sexual beings, especially not children that are vulnerable and you've spent your absolute life fighting to keep safe and have a place in society'* *'In an ideal world'* *'if I was involved with their care long term and was able to give him very intensive support, then yeah, I feel the outcome from would potentially be better'* *'if we had all the money in the world, could we do, you know, like, you know, could we reduce risk further'*
2. Confidence and competence	Anxiety provoking	Concept highly emotive/trauma Ignoring is also risky Working in the 'grey' area	*'quite a few of our people are coming through or getting referred because something's happened in the past or they've had some trauma previously'* *'a lot of people that we see, if they're wanting to have sex, they will find a way. And that's not necessarily the safest way'* *'They were trying to prove, wasn't they - whether he was actually, whether he was a victim or perpetrator'* *'Who's whose definition of safe are we using when we formulate about this?'*
	Lack of confidence	Little experience Our own position Responsibility	*'and the MDT have had to really be like encouraged to talk about this. And so you know, I wonder if … people don't ask them because people feel worried about it'* *'How comfortable do people really feel?'* *'what constitutes a kind of a healthy kind of relationship? So you kind of obviously bring to the table your own personal understanding and realisation of that'* *'it's good to pull on like the MDT when those sorts of issues arise and knowing who to refer to and whatsoever is to be involved'*
	Lack of knowledge	Sharing the learning 'Just Autism'	*'as a team, what we should maybe be better at doing is when we've had like a case study where there has been this risk and what we put in place, what's going well and what hasn't'* *'If they've got autism and they don't have a learning disability, they can't access our service'*

Themes	Subthemes	Codes	Example quotes
		Resources	*'I find it tricky when the client's autistic'* *'I think what would have been helpful … would be some sort of resource pack that has all the information around the capacity that you're assessing for and also the imagery because as I was kind of pulling it from lots of different places'* *'It exists. I've got laminated pictures of people having sex in the cupboard'*
3. Standardised vs. individual	Supporting a vulnerable population	Risk of exploitation	*'our guys don't always get that you know, just because you've talked to someone online doesn't mean you know them or they're your friend'* *'obviously people with learning disabilities are vulnerable people, aren't they? They're vulnerable population of society, so you know, they're vulnerable from all kinds of abuse. So, you know, sexual abuse is just another'*
		Safety = capacity	*'I'm not trying to exclude trans men or women in any kind of way, but, yeah, I think probably my female clients who are the people who would identify as female anyway, are more at risk of from men without learning disabilities.'* *'understanding behind that and whether there was what intentions were behind that and what was a lack of capacity'*
		Letting go of what we can't control	*'surface level of capacity or the impression that they might understand. And then once you kind of unpick that actually they don't'* *'so even though that they were having this discussion saying what they would do, they were then going into the community by themselves and then doing the complete opposite of that'*
	Person-centred care	'It's so individual'	*'[I] think it's really individual. That's what makes it difficult … that gets people a bit jumpy because you're like, so what is actually right for this person'*
		Outcome measures	*'I wonder about whether or not we need to think about whether it could be included in our outcomes'* *'But we know it has a huge relevance to people's actual outcomes, don't we?'*
		Idea that PWLD 'don't do that'	*'they are still people and they still have these feelings and urges and desires'*
	Routine assessment	Standardised part of assessment	*'making it more of a sort of a standardised part of the assessment process, maybe not in the first five minutes'*

Themes	Subthemes	Codes	Example quotes
		Risk assessment Whose job is it?	*'I think probably we could ask about it more. I expect it's not in initial core assessments … I think I say we don't mind talking about it, but we don't like to bring it up'* *'with the risk side of things recorded on a document, I think was quite reassuring for us'* *'I think it's more of a psychology domain kind of doing capacity assessments around sex'* *'if it was around if, say, it was around this, this particular issue and there was a psychologist involved and then or a social worker involved, I'd like to hope that they would do it'*

Appendix G - Reflexive Statement

I am a White British female in my early 30's, from a working-class family background in the Southeast of England. I do not have personal experience of intellectual disability; however, I do have some experience of working with community and inpatient learning disability teams and working clinically with intellectual disability populations, both mainstream and forensic. As such, I have come across issues of sexual risk and safety.

I have a strong view that the human rights of people with an intellectual disability are paramount and should be respected and facilitated. However, I have also been part of endeavours to keep service users and the general public safe from harm that may be posed by others, intentionally or otherwise.

I am aware of the power and privilege inherent in this work, that is held by us non-disabled professionals, and that there are often limited opportunities for service users with an intellectual disability to feel empowered and to act with agency in their lives. Being restrictive towards them, in regard to their sexual or other rights, is therefore a serious responsibility.

My undertaking of the interviews, analysis of the data, and subsequent working of themes was, therefore, inevitably shaped by these experiences and my views.

In addition, my position as a practicing clinician was particularly present during the data collection stage, and I was aware that at times I found it difficult not to reflect the interviewees experiences, and to simply ask questions for the purposes of information gathering.

It also became clear after the first few interviews, that interviewees were struggling to articulate exactly what they were doing to maintain the balance between sexual rights and sexual safety, other than that it is difficult. This required me to reflect with supervisors and revise the interview schedule somewhat, to better elicit specifics.

Appendix H - Lay Summary

The Oxfordshire Community Learning Disability Team (CLDT) consists of different professionals. They support individuals with a learning disability who also have a health need. Anecdotally, the CLDT reported that issues of sexual safety were becoming more frequent, and were difficult to manage, especially when trying to balance this with people's rights.

Throughout history, people with a learning disability have not been able to make choices about their lives and have been prevented from being in relationships and having sex. More recently, policies have been put into place to allow people with a learning disability to receive support that is tailored to them and allows them to pursue the kind of life they might have if they did not have a learning disability. At the same time, people with a learning disability can be vulnerable to different types of abuse and may need to be protected.

This project tried to find out how the team are balancing issues of sexual safety with allowing the people they support to engage in their sexual rights. The project also wanted to find out what things make this easier or more difficult. To do this, different staff members were interviewed. The transcripts from these interviews were analysed using a method of thematic analysis so that the ideas that came up could be organised into themes.

The three main themes were communication, confidence and competence, and standardised vs individual. These themes came from staff saying that they believe communicating knowledge about safe sex to people with a learning disability was important, but they sometimes did not feel comfortable or knowledgeable enough to discuss sex with their

patients themselves. Staff also struggled with balancing these things when each person is so different, and they could not just follow the same process every time.

From here, several recommendations were given to the service. These included building on staff's skills in this area, being clear about how risk is managed, creating shared resources, sharing times that things have gone well, and increasing access for people with a learning disability to get sex education. The team took on most of these recommendations.

Appendix I – Journal of Forensic Psychology Research and Practice Formatting Guidelines

Preparing Your Paper

Structure

Your paper should be compiled in the following order: title page; abstract; keywords; main text introduction, materials and methods, results, discussion; acknowledgments; declaration of interest statement; references; appendices (as appropriate); table(s) with caption(s) (on individual pages); figures; figure captions (as a list).

Word Limits

Please include a word count for your paper. There are no word limits for papers in this journal.

Style Guidelines

Please refer to these quick style guidelines when preparing your paper, rather than any published articles or a sample copy.

Please use American spelling style consistently throughout your manuscript.

Please use double quotation marks, except where “a quotation is ‘within’ a quotation”.

Please note that long quotations should be indented without quotation marks.

Formatting and Templates

Papers may be submitted in Word or LaTeX formats. Please do not submit your paper as a PDF. Figures should be saved separately from the text. To assist you in preparing your paper, we provide formatting template(s).

Word templates are available for this journal. Please save the template to your hard drive, ready for use.

A LaTeX template is available for this journal. Please save the LaTeX template to your hard drive and open it, ready for use, by clicking on the icon in Windows Explorer.

If you are not able to use the template via the links (or if you have any other template queries) please contact us here.

- **Further to the data sharing policy for the journal,** Data Note submissions must include a data availability statement and describe data available via a repository.

References

Please use this reference style when preparing your paper. An EndNote output style is also available to assist you.

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Checklist: What to Include

1. **Author details.** Please ensure all listed authors meet the Taylor & Francis authorship criteria. All authors of a manuscript should include their full name and affiliation on the cover page of the manuscript. Where available, please also include ORCiDs and social media handles (Facebook, Twitter or LinkedIn). One author will need to be identified as the corresponding author, with their email address normally displayed in the article PDF (depending on the journal) and the online article. Authors' affiliations are the affiliations where the research was conducted. If any of the named co-authors moves affiliation during the peer-review process, the new affiliation can be given as a footnote. Please note that no changes to affiliation can be made after your paper is accepted. Read more on authorship.
2. Should contain an unstructured abstract of 150 words. Read tips on writing your abstract.
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4. Do not include **keywords**. Read making your article more discoverable, including information on choosing a title and search engine optimization.
5. **Funding details.** Please supply all details required by your funding and grant-awarding bodies as follows:

   For single agency grants

   This work was supported by the [Funding Agency] under Grant [number xxxx].

For multiple agency grants

This work was supported by the [Funding Agency #1] under Grant [number xxxx]; [Funding Agency #2] under Grant [number xxxx]; and [Funding Agency #3] under Grant [number xxxx].

6. **Disclosure statement.** This is to acknowledge any financial or non-financial interest that has arisen from the direct applications of your research. If there are no relevant competing interests to declare please state this within the article, for example: *The authors report there are no competing interests to declare*. Further guidance on what is a conflict of interest and how to disclose it.
7. **Data availability statement.** If there is a data set associated with the paper, please provide information about where the data supporting the results or analyses presented in the paper can be found. Where applicable, this should include the hyperlink, DOI or other persistent identifier associated with the data set(s). Templates are also available to support authors.
8. **Data deposition.** If you choose to share or make the data underlying the study open, please deposit your data in a recognized data repository prior to or at the time of submission. You will be asked to provide the DOI, pre-reserved DOI, or other persistent identifier for the data set.
9. **Supplemental online material.** Supplemental material can be a video, dataset, fileset, sound file or anything which supports (and is pertinent to) your paper. Articles with extenders, such as infographics or video summaries, are up to 108% more likely to be downloaded (based on data in May 2024 from Plain Language Summary of Publication and Clinical Trial Protocol articles published in Future Oncology in 2023). We publish supplemental material online via Figshare. Find out more about supplemental material and how to submit it with your article. Taylor & Francis

Editing Services can help you create research promotion materials, including infographics, video abstracts, lay summaries and graphical abstracts, to support your article's impact. For more information, including pricing, visit this website.

10. **Figures.** Figures should be high quality (1200 dpi for line art, 600 dpi for grayscale and 300 dpi for colour, at the correct size). Figures should be supplied in one of our preferred file formats: PS, JPEG, TIFF, or Microsoft Word (DOC or DOCX) files are acceptable for figures that have been drawn in Word. For information relating to other file types, please consult our Submission of electronic artwork document.
11. **Tables.** Tables should present new information rather than duplicating what is in the text. Readers should be able to interpret the table without reference to the text. Please supply editable files.
12. **Equations.** If you are submitting your manuscript as a Word document, please ensure that equations are editable. More information about mathematical symbols and equations.
13. **Units.** Please use SI units (non-italicized).

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You must obtain the necessary permission to reuse third-party material in your article. The use of short extracts of text and some other types of material is usually permitted, on a limited basis, for the purposes of criticism and review without securing formal permission. If you wish to include any material in your paper for which you do not hold copyright, and which is not covered by this informal agreement, you will need to obtain written permission from the copyright owner prior to submission. More information on requesting permission to reproduce work(s) under copyright.

(including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

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

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

What are my notification responsibilities during the study?

The *"After HRA Approval – guidance for sponsors and investigators"* document on the HRA website gives detailed guidance on reporting expectations for studies with HRA and HCRW Approval, including:

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

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

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

Your IRAS project ID is **342400**. Please quote this on all correspondence.

Yours sincerely,

Rachel Katzenellenbogen

Approvals Specialist

Appendix K – OHFT Sponsorship Approval

Oxford Health
NHS Foundation Trust

Professor Vanessa Raymont
Research & Development Director
Warneford Hospital
Warneford Lane
Oxford
OX3 7JX
Email: research@oxfordhealth.nhs.uk

01/05/2025

Confirmation of Capacity and Capability

Re: The Impact of Relational Safety on Professional Quality of Life for Staff on Forensic Inpatient Units, and the Role of Self-Compassion.

Research and Development Reference: 18155
IRAS Reference: 342400
Sponsor: Oxford Health NHS Foundation Trust

Dear Amy Boucher-Thomas,

It is noted that the study commenced prior to formal confirmation of Capacity and Capability. As soon as this was identified, a risk-based decision was made and all research activity was paused. The C&C process was promptly initiated and has now been completed. On behalf of Oxford Health NHS Foundation Trust, I am pleased to confirm Trust Capacity and Capability for the above research as outlined in the application received.

Research activities at other sites cannot start until the following conditions have been met: PIC agreement between sponsor and participating organisation is signed, local C&C from participating site has been given, and green light notification from the sponsor is provided.

The study is not supported by a Research Delivery Team

Approved Documents

Protocol Version 4 dated 02/08/2024 is recognised as the most current to date.

The documents approved for use at this Trust are as listed in the following approval documents:
Health Research Authority Letter dated: 14/08/2024

Any subsequent, relevant amendments are additionally included to date.

Metrics and Recruitment

Recruitment target figure: 55
Recruitment target date: 31/08/2025
Anticipated study end date: 31/08/2025

To comply with national research performance requirements the Trust will monitor and publish recruitment for your study:

1. Performance of the recruitment of the first participant.
2. Recruiting planned participants to time and target.

Reporting recruitment via Siteline

As confirmed during the study set-up study accruals will be recorded via Siteline. It was agreed that Amy Boucher-Thomas will update the records at least once a month and no later than 7th of each month (e.g. by 7th August upload accruals for July etc.)

Should you feel at any time that you will be unable to realistically achieve your contracted recruitment target, please get in touch with the Research Team on research@oxfordhealth.nhs.uk as soon as possible.

Conditions of Approval

The following conditions apply to this approval:

a) The study is conducted in compliance with all the relevant legislation and the relevant OHFT policies.
b) All staff working on the study have the appropriate training and experience and have responsibilities formally delegated to them.
c) Should you plan to leave your position in OHFT, you will notify RD immediately of your plans, to enable discussions around the future of study conduct.
d) The Trust expects the named Principal Investigator to allocate regular support time to the study; this must be agreed with the research team prior to the study commencing. This may be reviewed by RD at any time.
e) All relevant documents will be maintained and will be sent to research@oxfordhealth.nhs.uk, to facilitate compliance checks, formal audits and regulatory inspections.
f) You will notify RD via the email above of any amendments.
g) You will promptly inform RD via the email above of progress and safety reports as well as the end of the study. For more detail, please refer to: Managing your approval - Health Research Authority (hra.nhs.uk).
h) You will respond in timely manner to RD periodic checks email.

NHS
Oxford Health
NHS Foundation Trust

I wish you every success with the study.

Yours sincerely,



Professor Vanessa Raymont
Director of Research Development

Appendix L – Participant Information Sheet





The Impact of Relational Security on Professional Quality of Life for Staff on Forensic Inpatient Units, and the Role of Self-Compassion

Participant Information Sheet

You are being invited to take part in a research project. Before you decide it is important to understand why the research is being done and what will be expected of you. Please take time to read the following information carefully and discuss it with others if you wish. If anything is unclear or you would like more information, please ask us by contacting the email address at the end of this sheet. Take time to decide whether you wish to take part in this research.

Why is this research being conducted?

Violence from patients towards staff is common in the NHS, particularly in forensic inpatient settings, and there is also a high rate of verbal aggression and threats. This can lead to burnout, poor wellbeing, and poor mental health, which has an impact on individuals and services.

There are three elements to security in secure healthcare settings. These are physical, procedural, and relational. Relational security is the understanding staff have of a patient and the environment, and how we use this to inform our responses. There is a lack of research into relational security and the factors which affect it.

This study aims to investigate how relationally secure staff working on forensic inpatient wards feel, and whether this is associated with their professional quality of life. We also aim to explore whether self-compassion has any impact on this.

It is hoped that this may lead to improvements in staff support, increased relational security for staff and service users, and fewer factors that negatively impact patient care such as staff turnover.

Why have I been invited to take part?

You have been invited to take part as you are a staff member working on a forensic inpatient unit.

Do I have to take part?

No. Your participation is entirely voluntary. You will be asked for your consent if you decide to take part. You are free to change your mind and withdraw at any time while

completing the online questionnaires. The questionnaires are in two parts. At the end of the first and second part, you will be asked if you would like to continue or to stop and withdraw from the study. If you decide to stop and withdraw from the study, we will delete any data you have already provided and will ensure your responses are removed.

If you decide not to take part, you do not have to give a reason and there will be no negative consequences for you.

Once your responses have been submitted you will be unable to withdraw as responses are anonymised.

What will happen if I decide to take part?

After reading this information sheet, the next page will ask you to give your informed consent to take part by ticking the appropriate box.

You will then be asked to answer a series of questions about you, your relational security at your main place of work, your quality of life and wellbeing, and your compassion towards yourself. It is estimated that all the questions will take no more than 15 minutes to complete.

What are the benefits and risks of taking part?

Some questions relate to your sense of security and your current wellbeing. You may find some of the questions difficult to answer or upsetting. If you find any of the questions distressing, you can withdraw from the study at any time prior to completion.

At the end of the study, you will be provided with contact details of services and organisations that can offer support and guidance if you experience distress.

We hope that the findings of this study will be used to better understand relation security and associated factors, which will hopefully improve support to staff on forensic inpatient units. Whilst this does not provide immediate benefit to participants taking part in this study, it may benefit you and others in the future.

How will my data be used and stored?

Before the main questionnaires, you will be asked to complete some questions about you, such as your age, gender, and ethnicity. All data will remain anonymous and will be stored on a password protected NHS Trust device and deleted after five years.

Data will be managed in adherence with Oxford Health NHS Foundation Trust (OHFT) Privacy Policy. You will not be asked to provide any personal information that could

completing the online questionnaires. The questionnaires are in two parts. At the end of the first and second part, you will be asked if you would like to continue or to stop and withdraw from the study. If you decide to stop and withdraw from the study, we will delete any data you have already provided and will ensure your responses are removed.

If you decide not to take part, you do not have to give a reason and there will be no negative consequences for you.

Once your responses have been submitted you will be unable to withdraw as responses are anonymised.

What will happen if I decide to take part?

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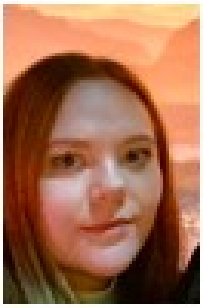
Data will be managed in adherence with Oxford Health NHS Foundation Trust (OHFT) Privacy Policy. You will not be asked to provide any personal information that could

If you have any questions about the study, please contact the main investigator:

Amy Boucher-Thomas, Trainee Clinical Psychologist
Oxford Institute for Clinical Psychology Training and Research
Isis Education Centre
Warneford Hospital
Headington, Oxford
OX3 7JX
amy.thomas@gtc.ox.ac.uk



GDPR Data Management Statement

All data collected will be collected in line with the Data Protection Act 2018 and GDPR (General Data Protection Regulations). Data collection will also comply with the Common Law Duty of confidentiality. Oxford Health NHS Foundation Trust is the data controller and is responsible for looking after your information and using it properly. Health and care research should serve the public interest, which means that we have to demonstrate that our research serves the interests of society as a whole. We do this by following the UK Policy Framework for Health and Social Care Research. Data protection regulation requires that we state the legal basis for processing information about you. In the case of research, this is 'a task in the public interest.' You can find out more about how we use your information at https://www.oxfordhealth.nhs.uk/privacy/.
If you wish to raise a complaint on how we have handled your personal data, you can contact our Data Protection Officer who will investigate the matter. If you are not satisfied with our response or believe we are processing your personal data in a way that is not lawful you can complain to the Information Commissioner's Office (ICO) (www.ico.org or 0303 123 1113).

Appendix M – Consent Form





The Impact of Relational Security on Professional Quality of Life for Staff on Forensic Inpatient Units, and the Role of Self-Compassion

Online Participant Consent Form

This study aims to survey staff who work on forensic inpatient units about their sense of relational security, their professional quality of life, and their compassion towards themselves. We hope that this project will help services to better understand relational security and factors associated with it.

Please tick the box to confirm

1. I confirm that I have read and understood the information sheet dated 04.05.24/version 2 for the above study. I have had the opportunity to consider the information carefully, ask questions, and have had these questions answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any point without giving a reason and without penalty, until I have submitted my responses. ☐
3. I understand that the information I provide as part of this study will be kept confidential and only the research team will have access to it. ☐
4. I understand how my data will be stored and what will happen to the data at the end of the study. ☐
5. I understand that I will not be identifiable from any publications, reports, or presentations that are made using results from the study. ☐
6. I understand how to raise a concern or make a complaint. ☐
7. I agree to take part in the study. ☐

Appendix N – Debrief Information





Participant Debrief Information

Thank you very much for taking part in this study.

More information about this research

Staff safety in healthcare settings is important. Threats towards staff can lead to difficulties for the individual, such as poor wellbeing and mental health, in addition to the service, for instance staff turnover and sick leave.

Physical and verbal aggression towards staff is common in forensic inpatient settings and relational security has been identified as a factor in this. There is little research into understanding relational security and the factors that are associated with it.

The results from the questionnaires you have completed are helpful in developing our understanding of relational security, how this impacts on professional quality of life, and any role self-compassion plays in this. This may lead to the development of improved support for staff, so thank you for your time.

Who to contact for further advice and support

If answering the questions in this study has led you to experience any distress, please consider the following sources of support:

- It may be useful for you to speak to your line manager, clinical supervisor, or a trusted colleague if you are concerned about your wellbeing in relation to your work
- Access your Employee Assistance Programme or equivalent through your Trust's intranet page
- Contact your GP or other healthcare professional
- Call Samaritans listening service at anytime, on 116 123
- Go to your local A&E department or call 999 if you are in need or urgent support, or feel you are unable to keep yourself safe

Further questions

If you have any more questions about this research, please contact the main investigator Amy Boucher-Thomas (amy.thomas@gtc.ox.ac.uk), or their supervisor Dr Canan Bektas, (canan.bektas@psy.ox.ac.uk) and they will do their best to answer your query.

Appendix O – See Think Act Scale ([STA], Tighe & Gudjonsson, 2012)

Appendix P - Self-Compassion Scale – Short Form ([SCS-SF], Raes et al., 2011)

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. When I fail at something important to me I become consumed by feelings of inadequacy.

_____2. I try to be understanding and patient towards those aspects of my personality I don't like.

_____3. When something painful happens I try to take a balanced view of the situation.

_____4. When I'm feeling down, I tend to feel like most other people are probably happier than I am.

_____5. I try to see my failings as part of the human condition.

_____6. When I'm going through a very hard time, I give myself the caring and tenderness I need.

_____7. When something upsets me I try to keep my emotions in balance.

_____8. When I fail at something that's important to me, I tend to feel alone in my failure _____9. When I'm feeling down I tend to obsess and fixate on everything that's wrong.

_____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 disapproving and judgmental about my own flaws and inadequacies.

_____12. I'm intolerant and impatient

Appendix Q - Professional Quality of Life Scale ([ProQoL] Stamm, 2010)

	Never	Rarely	Sometimes	Often	Very Often
I am happy.	**5**	**4**	**3**	**2**	**1**
I am preoccupied with more than one person I [help].	**1**	**2**	**3**	**4**	**5**
I get satisfaction from being able to [help] people.	**1**	**2**	**3**	**4**	**5**
I feel connected to others.	**5**	**4**	**3**	**2**	**1**
I jump or am startled by unexpected sounds.	**1**	**2**	**3**	**4**	**5**
I feel invigorated after working with those I [help].	**1**	**2**	**3**	**4**	**5**
I find it difficult to separate my personal life from my life as a [helper].	**1**	**2**	**3**	**4**	**5**
I am not as productive at work because I am losing sleep over traumatic experiences of a person I [help].	**1**	**2**	**3**	**4**	**5**
I think that I might have been affected by the traumatic stress of those I [help].	**1**	**2**	**3**	**4**	**5**
I feel trapped by my job as a [helper].	**1**	**2**	**3**	**4**	**5**
Because of my [helping], I have felt "on edge" about various things.	**1**	**2**	**3**	**4**	**5**
I like my work as a [helper].	**1**	**2**	**3**	**4**	**5**
I feel depressed because of the traumatic experiences of the people I [help].	**1**	**2**	**3**	**4**	**5**
I feel as though I am experiencing the trauma of someone I have [helped].	**1**	**2**	**3**	**4**	**5**
I have beliefs that sustain me.	**5**	**4**	**3**	**2**	**1**
I am pleased with how I am able to keep up with [helping] techniques and protocols.	**1**	**2**	**3**	**4**	**5**
I am the person I always wanted to be.	**5**	**4**	**3**	**2**	**1**
My work makes me feel satisfied.	**1**	**2**	**3**	**4**	**5**
I feel worn out because of my work as a [helper].	**1**	**2**	**3**	**4**	**5**
I have happy thoughts and feelings about those I [help] and how I could help them.	**1**	**2**	**3**	**4**	**5**
I feel overwhelmed because my workload seems endless.	**1**	**2**	**3**	**4**	**5**
I believe I can make a difference through my work.	**1**	**2**	**3**	**4**	**5**
I avoid certain activities or situations because they remind me of frightening experiences of the people I [help].	**1**	**2**	**3**	**4**	**5**

I am proud of what I can do to [help].	**1**	**2**	**3**	**4**	**5**
As a result of my [helping], I have intrusive, frightening thoughts.	**1**	**2**	**3**	**4**	**5**
I feel "bogged down" by the system.	**1**	**2**	**3**	**4**	**5**
I have thoughts that I am a "success" as a [helper].	**1**	**2**	**3**	**4**	**5**
I can't recall important parts of my work with trauma victims.	**1**	**2**	**3**	**4**	**5**
I am a very caring person.	**5**	**4**	**3**	**2**	**1**
I am happy that I chose to do this work.	**1**	**2**	**3**	**4**	**5**

Appendix R - Holm-Bonferroni Correction Table for Relational Security Hypotheses

Dependent Variable	P-value	Rank	Corrected α threshold	Significant after correction
Secondary Traumatic Stress	.006	1	.05 / 3 = .0167	Yes
Compassion Satisfaction	.018	2	.05 / 2 = .025	Yes
Burnout	.067	3	.05 / 1 = .05	No