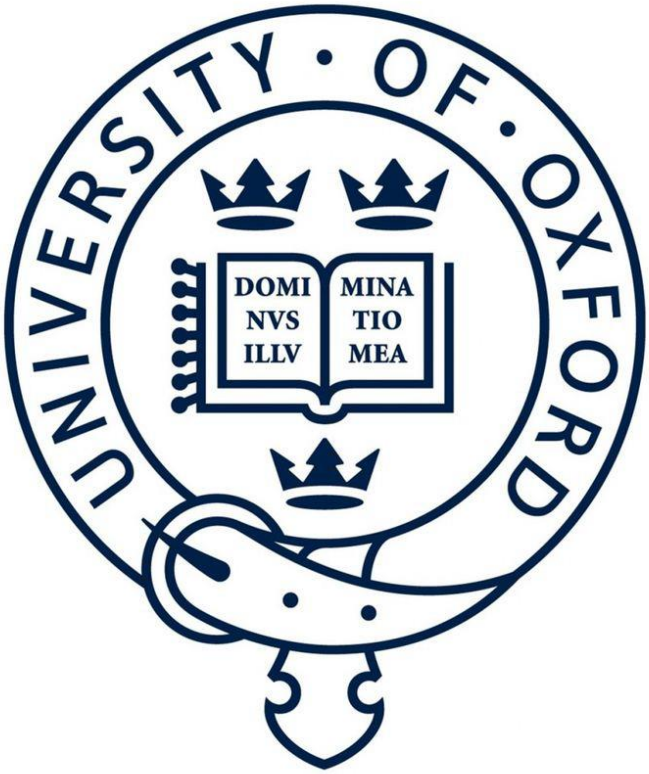
Thesis submitted in partial fulfilment of the requirements of the degree of Doctor of Clinical Psychology (DClinPsy)

# The Challenges of Connecting After Interpersonal Trauma

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## Abstracts


### Systematic Literature Review

*A review of interpersonal functioning following the trauma of interpersonal violence*

Interpersonal trauma has broad psychological consequences and can cause disturbances in relationships. Though these difficulties may not fit any specific diagnostic criteria they still require our attention since good interpersonal functioning has a profound impact on mental and physical health outcomes and is a primary concern for the affected population. Research is needed on the relationship between interpersonal trauma and interpersonal functioning beyond diagnosis, as this is crucial to understanding the impacts of interpersonal trauma and developing targeted interventions.

The aim of this review is to provide a comprehensive summary of the existing evidence on interpersonal functioning in survivors of adult interpersonal trauma. Three databases were searched, and 15 quantitative studies were identified which examined interpersonal functioning in adults with a history of interpersonal trauma occurring during adulthood (age 18 or above).

The findings of this review suggest that there is a negative relationship between exposure to interpersonal trauma and interpersonal functioning. These difficulties are summarised around four themes that emerged: interpersonal trauma and attachment, specific relationships, schemas and behaviours.

The literature reviewed supports the idea that exposure to adult interpersonal trauma is associated with relational functioning difficulties, though definitive conclusions could not be drawn. Across papers, the event of interpersonal trauma or its experience was associated with insecure attachment styles, schema disruptions, and behavioural difficulties across a range of contexts (romantic, infant, community etc.).

Future research should address significant methodological concerns including the role of confounds, sampling bias, and measurement issues, to better understand the mechanisms that influence relationship quality and quantity. Considering the importance of relationships for good health outcomes, future interventions should be tailored to supporting survivors interpersonally beyond diagnosis and within the therapeutic relationship.

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**Service Improvement Project**

*Mapping the needs of special guardianship kinship carers order*

Research suggests that special guardian order (SGO) kinship carers for children have fewer personal resources, face increased challenges/responsibilities/demands and yet receive less support from services than other carers. This impacts their well-being as well as the stability of placements. Carers cannot meet the needs of the child and their own needs without support. We consider Bronfenbrenner's bio-ecological model and aim to identify carers' unmet needs and the support they require for them to fulfil their role and realise their potential for effective functioning.

This service improvement project interviewed (SGO) kinship carers offered support by a local authority psychological service for adoptive, special guardianship and foster care families to identify their unmet needs when accessing the service in relation to the different layers of Bronfenbrenner's bio-ecological model.

An interview schedule was developed collaboratively with the service team. Qualitative data from 5 semi-structured interviews of 7 service users' experience was collated and analysed. A thematic analysis of the data showed that carers struggled to navigate services and access support, negotiate relationships in the new family structure, and care for children with complex needs in adversity. These challenges impacted on the carers' well-being and insufficient support was available to meet their needs. Recommendations to provide support that more adequately meets carers needs were developed, incorporating participants feedback and shared with the service along with findings. An implementation plan is being developed.

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**Theoretically Driven Research Project**

*Sensitivity to betrayal and new intimate relationship building in survivors of intimate partner violence*

**Objectives** Betrayal sensitivity is conceptualised as how sensitive someone is to the possible experience of further betrayal and the subsequent negative impact of such betrayals. There is evidence which suggests that prior experience of IPV can lead to high levels of sensitivity to betrayal, shame, and self-criticism and therefore may interfere with initiation, development and maintenance of future intimate relationships. We aimed to examine levels of betrayal, shame, and self-criticism in women survivors of IPV, and to evaluate whether survivors who are satisfied with their intimate relationships – as well as women without a history of IPV- are less sensitive to being betrayed compared to those dissatisfied with their relationships or single.

**Design** A cross-sectional, between-groups design was used, comparing women survivors of IPV divided into those satisfied with current intimate relationships, those dissatisfied and IPV survivors not in such a relationship. Women without a history of IPV were included as a benchmark group.

**Method** Four groups: IPV single (N= 34), IPV dissatisfied (N= 25), IPV satisfied (N=32), and those who had not experienced IPV (N= 42) were compared for betrayal sensitivity, followed by a secondary comparison of shame and self-criticism. Questionnaires were completed online by participants recruited through social media and screened for IPV and relationship status.

**Results** All IPV groups had significantly higher scores for betrayal sensitivity than the non-clinical group, with IPV Satisfied having significantly lower scores than other IPV groups in two subscales: betrayal causing life change and lack of trust due to betrayal.

**Conclusions** Betrayal sensitivity is present amongst all survivors of IPV with evidence of a specific link between survivors' relationship satisfaction/status and their lack of trust and being permanently changed beliefs. It may be that those appraisals make it more challenging to build and maintain satisfactory relationships, or that positive relationships help survivors change their appraisals about betrayal leading to lack of trust and life altering changes.

**Key words:** 'Intimate Partner Violence', 'Betrayal', 'Relationships' 'Self-criticism', 'Shame'

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**Systematic Literature Review (SLR)**

# A review of interpersonal functioning following the trauma of interpersonal violence

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## Abstract

Interpersonal violence is a global concern due its prevalence and its range of mental health consequences. Recent research has focused on understanding the interpersonal features of complex trauma. The main concern for the population is the interpersonal difficulties resulting from interpersonal trauma. Unhelpful interpersonal coping styles can impact interpersonal functioning and building, leading to isolation and impoverished support networks, which are crucial for protecting against mental health problems and trauma. Current research has not yet fully addressed these interpersonal difficulties.

The aim of this review is to provide a comprehensive summary of the existing evidence on interpersonal functioning in survivors of adult interpersonal trauma. We systemically reviewed 15 quantitative studies examining interpersonal functioning in adults with a history of interpersonal trauma occurring during adulthood (age 18 or above). The literature reviewed supports the idea that exposure to adult interpersonal trauma is associated with relational functioning difficulties. Across papers, the event of interpersonal trauma or its experience was linked to insecure attachment styles, schema disruptions, and behavioural difficulties across a range of contexts (romantic, infant, community etc.).

Future research should focus on addressing significant methodological concerns, refining measures and constructs, and gaining a better understanding of the mechanisms by which different factors affect the quality and quantity of relationships. Considering the importance of relationships for good health outcomes, future interventions should be tailored to supporting survivors interpersonally beyond diagnosis and within the therapeutic relationship.

## Introduction

Interpersonal violence involves "the intentional use of physical force or power against other persons by an individual or small group of individuals" (Mercy et al., 2017). It can be physical, sexual, or psychological (or emotional) violence and can be subdivided into *family and intimate partner violence (IPV)* and *community violence* (*World Report on Violence and Health*, 2002). This review will consider interpersonal trauma which refers to the psychological experience of interpersonal violence in adulthood.

### The Psychological Difficulties Associated with Interpersonal Trauma

A growing body of evidence suggests experiencing interpersonal trauma is associated with a range of mental health difficulties including depression, anxiety disorders and PTSD (Follette, Palm, & Hall, 2004), and even personality disorders (D'Andrea, Ford, Stolbach, Spinazzola, & Van der Kolk, 2012; van Dijke et al., 2012). When compared to patients with trauma not involving an interpersonal dimension (e.g., natural disasters or motor vehicle accident), patients with sexual and physical trauma display increased severity and chronicity in PTSD symptom presentation (Smith, Summers, Dillon, & Cougle, 2016).

Interpersonal trauma consequences are broad and hard to contain within "*discrete diagnostic categories*" (Stein & Allen, 2007). Symptoms related to interpersonal functioning following interpersonal violence are increasingly being considered in the conceptualisation and revisions of psychiatric disorders. A hallmark example relates to the complex PTSD diagnosis (CPTSD; Cloitre, Garvert, Brewin, Bryant, & Maercker, 2013; Herman, 1992). Its aetiology and presentation (Van Nieuwenhove & Meganck, 2019) were developed to capture the pervasive and enduring symptoms (e.g., disturbances in relationships) that occur following repeated and prolonged exposure to interpersonal trauma, which were previously neglected in the previous PTSD diagnostic criteria (World Health Organization, 1992). This

recent interest in interpersonal functioning fits interpersonal trauma survivors' treatment priorities, who aim to target interpersonal and emotional regulation difficulties in treatment above the core PTSD symptoms (van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). Beyond diagnosis, there could be substantial distress and dysfunction resulting from interpersonal trauma that do not fully meet any diagnostic criteria (Stein & Allen, 2007) but still merits our attention.

**Interpersonal Functioning**

Despite widespread use, the term "interpersonal functioning" – which pertains to events, actions, thoughts or feelings between two or more individuals – is seldom operationalised in associated reviews (Davis & Petretic-Jackson, 2000). The terminology seems to change depending on the research community despite it measuring the same phenomena (Leising, Krause, Köhler, Hinsen, & Clifton, 2011). Beyond the definitional issues, there have also been methodological issues around measurement, sampling bias, and unknown confounding variables (DiLillo, 2001).

In as much as it determines the quality of our relationships, good interpersonal functioning is essential to mental and physical health. Relationships markedly impact all health outcomes and have the potential to be both an advantage or disadvantage depending on their quantity and quality (Umberson & Karas Montez, 2010). Relationship quality can impact mental health symptoms and recovery (J. Wang, Mann, Lloyd-Evans, Ma, & Johnson, 2018), for example, it has been shown that poor social support is a key factor in PTSD chronicity (C. R. Brewin, Andrews, & Valentine, 2000). Experience of stigma, including negative responses to disclosure from peers and the community (i.e., societal betrayal) is associated with worse psychopathology. Conversely, positive interactions are protective (Dworkin, Brill, & Ullman, 2019). Survivors with CPTSD have reported that rebuilding relationships based on trust, starting with the therapist, was essential to recovery (Matheson

& Weightman, 2021). Unfortunately, the impacts of trauma itself, such as interpersonal difficulties (Peter Roy-Byrne, 2015), may make it harder to maintain social support networks and therefore lead to isolation.

## Conceptual frameworks

To ensure a psychologically focused and comprehensive review, we reviewed conceptual frameworks that exist for understanding interpersonal functioning, including both attachment and cognitive theory, and integrated the associated terminology in our search strategy.

### *Attachment Theory*

According to Bowlby's attachment theory (Bowlby, 1958, 2005), social interactions with significant others become internal working models of self and others which shape how individuals perceive and cope with relationships in adulthood (Mikulincer & Shaver, 2007). The systematic patterns of expectations, beliefs, and feelings individuals have about others' responses to them is referred to as an attachment style. Research on the impact of interpersonal violence on attachment suggests that exposure to violence could disrupt attachment security (Allen, 1995, 2018), leading to the development of insecure attachment such as avoidant–dismissive and anxious–resistant (Ainsworth, Blehar, Waters, & Wall, 1978). In their close relationships, anxiously attached individuals may be increasingly vigilant, seeking reassurance and dependency, in response to a fear of abandonment and being unworthy of care (Kobak, Cole, Ferenz-Gillies, Fleming, & Gamble, 1993), and avoidant ones may have difficulties with close relationships, excessively relying on themselves and suppressing emotions (Mikulincer & Shaver, 2007).

Insecure attachment styles can increase interpersonal difficulties such as greater conflict (Campbell, Simpson, Boldry, & Kashy, 2005; Saferstein, Neimeyer, & Hagans,

2005), lowering social competence (Mallinckrodt & Wei, 2005) and quality of romantic relationships (Holland, Fraley, & Roisman, 2012; Klohnen & Bera, 1998). However, most of the literature is focused on the impact of interpersonal trauma during childhood (but not adulthood) on attachment, with some recent exceptions (Mikulincer, Ein-Dor, Solomon, & Shaver, 2011; Ogle, Rubin, & Siegler, 2015).

In conclusion, attachment theory could help explain the association between exposure to traumatic violence and issues with interpersonal functioning (such as difficulties building and maintaining relationships) by way of attachment dimension.

***Cognitive Theory***

Cognitive theory, via the concept of "schemas", offers a useful framework for understanding the interpersonal difficulties experienced by survivors of violence. Schemas refer to an individual's overarching beliefs and patterns of thinking about themselves, others, and the world. These are accessed to help understanding or action (Scarvalone, Fox, & Safran, 2005). Traumatic experiences can disrupt an individual's foundational beliefs about the world, self, and others, and as such have a lasting impact on an individual's sense of safety and trust, emotion regulation (Everly Jr & Lating, 2004; SAMHSA, 2014) and overall psychological well-being (Goldberg & Freyd, 2006; Koss et al., 1994). Due to potential closeness to the perpetrator, interpersonal traumas are more likely to alter schemas of trust and intimacy eliciting feelings of shame and betrayal (Everly Jr & Lating, 2004; van der Kolk et al., 2005) and impacting an individual's response to other interpersonal events (McCann, Sakheim, & Abrahamson, 1988). Thus, cognitions about interpersonal relationships (in the form of altered schemas) can result in behavioural avoidance and numbing strategies, which predict and maintain interpersonal difficulties (Patricia A. Resick, Monson, & Chard, 2017).

Survivors' behaviour in their relationships may be modified by the disruptions to their schemas or their insecure attachment style, thus resulting in interpersonal problems and concrete alterations to their relationships. Using the concept of schemas and attachment to understand the interpersonal consequences of psychological adaptations to interpersonal trauma exposure could support the development of effective interventions for survivors of violence.

**Conclusion and review question**

Survivors' interpersonal difficulties have been a treatment challenge and improvement of relational outcomes has been limited (Swerdlow et al., 2023). A foundational review from three decades ago urged the field to consider research into "*the domains of intra- and interpersonal functioning*" associated with interpersonal violence (Weaver & Clum, 1995). Since this review from 1995, no other review has examined the impact of interpersonal trauma on relational outcomes without focussing on the impact on diagnostic categories. Several papers have studied specific elements of interpersonal functioning in survivors (Jellestad, Vital, Malamud, Taeymans, & Mueller-Pfeiffer, 2021; Taft, Watkins, Stafford, Street, & Monson, 2011), or reported the prevalence of interpersonal problems, however none have recently attempted to systematically document those interpersonal difficulties. A comprehensive overview of those difficulties in survivors is needed to help clinicians and researchers target and develop interventions.

We sought to systematically review studies of adults (from age 18) which investigate measures of interpersonal functioning following exposure to interpersonal trauma in adulthood. Our research question was: "What are the interpersonal functional outcomes (e.g., disturbances in relationships) of exposure to interpersonal violence?" It was hypothesised that exposure to interpersonal trauma may be associated with interpersonal difficulties. As there is a breadth of research on childhood trauma and subsequent interpersonal difficulties in

adulthood (Van Nieuwenhove & Meganck, 2019), this review will focus on interpersonal trauma experienced in adulthood only to address a gap in the literature. It aims to contribute a review of the interpersonal functioning difficulties following the trauma of interpersonal violence to help better understand the needs of this population and tailor the provision of services and support.

# Methods

## Search strategy

This systemic review was registered with Prospero and followed the Preferred Reporting Items for Systematic Reviews and Meta-analyses guidelines (PRISMA; Moher et al., 2009). Electronic databases Embase, MEDLINE, PsycINFO were searched for articles published from 1995 to 14th of October 2022. The search strategy was developed and refined after keyword searches and discussions with the librarian and co-authors. A search of titles, abstracts, and subject headings (MeSH; where possible) was conducted to increase search sensitivity for the following concepts: interpersonal trauma (e.g., search terms: “interpersonal trauma" OR “complex trauma”) and interpersonal functioning (types of relationship, skill and difficulties, measures) (e.g., search terms: "interpersonal functioning" OR “trust”). The full search strategy and the exclusion/inclusion criteria are included in Appendix A. The following limits were imposed during the search: Human, English, Adult, Peer reviewed Journal (available in PsycINFO only).

## Inclusion and Exclusion Criteria

Papers were included if they were empirical studies using quantitative methodology, written in English language and published in peer reviewed journals. Quantitative methods were preferred. Population needed to be human adults over the age of 18 with a history of interpersonal trauma defined as traumatic or highly stressful events with a relational component

(e.g., domestic, physical, sexual or emotional violence/abuse) and not childhood trauma. Considering some overlap of adult and childhood interpersonal trauma, a threshold of 50% was set: all studies primarily focused on childhood trauma or where it was reported that more than 50% of the participants were exposed to this trauma were excluded. Participants in cohort studies' comparison groups were either survivors of non-interpersonal trauma or no trauma. In accordance with recommended practice (Tanner-Smith & Wilson, 2013), we also excluded papers with specialised populations (e.g. forensic populations). Papers were excluded if participants were under 18, childhood, combat or war trauma survivors, or if interpersonal trauma was not considered as the exposure (Independent Variable) and interpersonal functioning as the outcome (Dependent Variable).

Identified studies were imported into Endnote and duplicates were removed. The lead author screened titles and abstracts first, and then full texts to determine to eligibility. A second rater independently reviewed 20% of the papers and any discrepancies were resolved. The achieved agreement for inter-rater reliabilities was good to excellent with Cohen's kappa =.81 for initial screening; Cohen's kappa =1.00 for full-text screening (Altman, 1991).

**Data Synthesis**

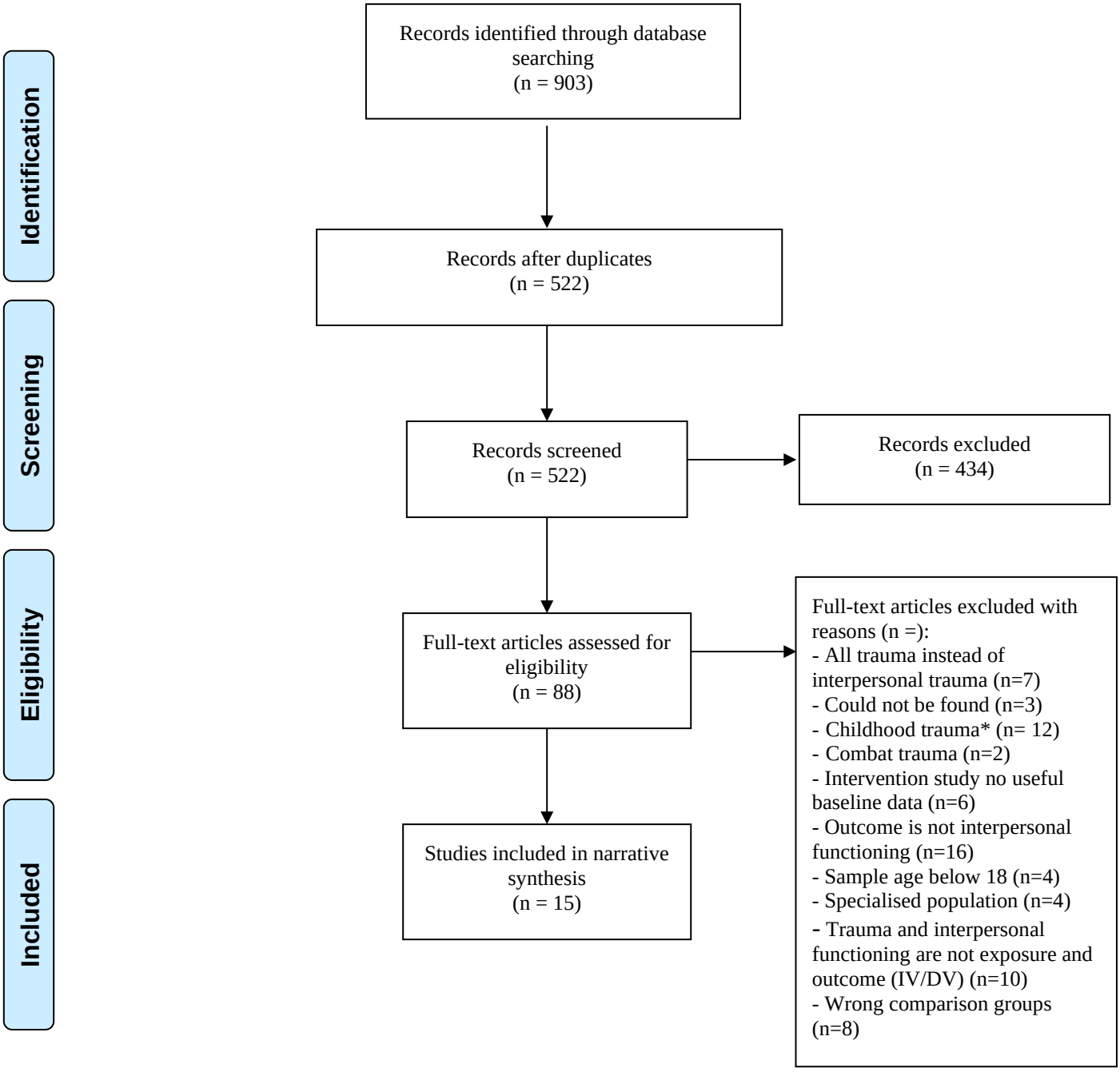
The following information was extracted from the papers: sample size, age, gender, type and setting, as well as study design, country, ethnicity, interpersonal trauma measure, type, comparison group, and interpersonal functioning measure. A narrative account of the findings was the most appropriate strategy because of the heterogeneity of the outcome measures and study designs.

My position as a woman and a mental health professional with extensive experience working with trauma populations, meant that I had a natural alliance with survivors and an interest in their outcomes, quality of life and overall recovery. As a clinical psychologist, I am aware of the discourses of dissatisfaction around the lack of quantitative research on

interpersonal outcomes for survivors beyond basic daily functioning for survival. However, survivors' distress is often focussed on challenges of connection. Working with service users in mental health services, I felt that quantitative approaches are being favoured by commissioners and for best practice guidance, thus holding more power and influence over service users' experiences and outcomes. However, I noticed that interpersonal consequences and relationship quality were favoured in the literature by qualitative approaches. There appeared to be a gap in the literature, a dearth of quantitative research, around interpersonal outcomes despite being critical issues for survivors. I hoped this review would highlight the sparse nature of the existing literature and the need for further quantitative research. A narrative synthesis enabled me to include hard to compare constructs and measurement tools which could not be used in a meta-analysis. I was able to provide a more nuanced account of the literature with much needed clarifications of constructs or detail of study limitations to make sense of the evidence.

Quality assessment was performed using the NIH Study Quality Assessment Tools (National Institutes of Health, 2014). A second rater coded and appraised 30% of papers. Inter-rater reliabilities were excellent for both data extraction: Cohen’s kappa =.96; and quality assessment: Cohen’s kappa=.90 (Altman, 1991).

*Figure 1.* Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) flow diagram of search strategy



# Results

The studies' key characteristics, measures of interpersonal trauma and interpersonal functioning were reviewed. This was followed by a narrative synthesis of the findings which were structured around four themes: the relationship between interpersonal trauma and (i) attachment styles, (ii) different types of relationships, (iii) beliefs about others (e.g., intimacy and trust), and (iv) interpersonal behaviours.

## Study Characteristics

Number of participants ranged from 105 to 705, eight of the samples included between 100 – 250 participants. Only studies focused on adult population were included and the mean age ranged between 19.27 to 38.9. Seven studies recruited participants in the community, four included student populations and four clinical populations. Eleven studies came from the USA – expectedly so considering English language was a search requirement– two from European countries, and one from Asia (Taiwan). All studies but one, were predominantly female, with eight exclusively so. Female/male were the only gender identities reported. In the Western studies, a majority of participants self-identified as White or Caucasian, except for one where Black predominated (Lathan, Selwyn, & Langhinrichsen-Rohling, 2021). Two studies did not report detailed data on ethnicity: one from Taiwan and one from Spain.

## Interpersonal Trauma Measures

Studies greatly varied in their assessment of interpersonal trauma ranging from a single standardised self-report measure (n=12) to three more extensive and bespoke compilation of multiple assessment tools (Kolk et al., 2021; Reich, Blackwell, Simmons, & Beck, 2015; Wright, Collinsworth, & Fitzgerald, 2010). See Table 1. All studies but one (composite lifetime trauma measure; Kolk et al., 2021) used a validated self-report measure at least once to determine interpersonal trauma exposure. Two studies used modified versions

of the TLEQ or LEC (Lathan et al., 2021; Sandberg & Refrea, 2022), one used sections of diagnostic interviews (PDS; Woodhouse, Brown, & Ayers, 2018); and another a criterion A of IPV interview (Reich et al., 2015).

Trauma was measured using scales, surveys and questionnaires and were used to screen participants for exposure to interpersonal trauma and/or allocate to a group. The Traumatic Life Events Questionnaire (TLEQ; E. S. Kubany et al., 2000) and its modified variant were the most frequently used (n=3), followed by the Life Events Checklist (LEC; Gray, Litz, Hsu, & Lombardo, 2004) or its variant (LEC-5; Weathers et al., 2013) (n=2).

Five studies focused predominantly on partner abusive behaviours. Two studies (Reich et al., 2015; Torres et al., 2013) used general measures of IPV: Index of Spouse Abuse (ISA; Hudson & McIntosh, 1981) and Revised Conflict Tactic Scales (CTS-2; Straus, Hamby, Boney-McCoy, & Sugarman, 1996). Three studies specified the type of abuse: Psychological Maltreatment of Women Inventory-Short Form (PMWI-SF; Tolman, 1999) (Reich et al., 2015), Adult Physical Assault Scale (APA; Shepard & Campbell, 1992), Sexual Experiences Survey (SES; Koss & Gidycz, 1985) (Wright et al., 2010) and gendered violence with the Severity of Violence Against Women Scales (SVAWS; Marshall, 1992) (Kobayashi, Levendosky, Bogat, & Weatherill, 2021). One study determined relationship to perpetrator or trauma with the Brief Betrayal Trauma Survey (BBTS; Goldberg & Freyd, 2006) (Belford, Kaehler, & Birrell, 2012).

**Interpersonal Functioning Measured Outcomes**

Seven studies assessed general attachment patterns whether categorical or dimensional (Bistricky et al., 2017; Fowler, Allen, Oldham, & Frueh, 2013; Huang, Chen, Su, & Kung, 2017; Sandberg & Refrea, 2022; Sandberg, Suess, & Heaton, 2010; Wiltgen, Arbona, Frankel, & Frueh, 2015; Woodhouse et al., 2018).

Four studies aimed to examine the association between trauma and the quality of connection and attachment specific to certain relationships, including adult romantic (Jaffe, DiLillo, Gratz, & Messman-Moore, 2019; Kobayashi et al., 2021), parent-infant (Kobayashi et al., 2021; Kolk et al., 2021), mentor and peer (Belford et al., 2012) and social acknowledgment (Woodhouse et al., 2018).

Four studies examined associations between trauma and interpersonal beliefs such as betrayal, trust, intimacy and rejection by selecting specific subscales from validated measures/questionnaires (Jaffe et al., 2019; Lathan et al., 2021; Torres et al., 2013; Wright et al., 2010).

Finally, four studies (Bistricky et al., 2017; Reich et al., 2015; Torres et al., 2013; Woodhouse et al., 2018) looked at the behavioural components (e.g., social problem solving) of interpersonal functioning (Bistricky et al., 2017; Reich et al., 2015; Torres et al., 2013; Woodhouse et al., 2018). Three used the following validated measures: Interpersonal Competence questionnaire (ICQ; Buhrmester, Furman, Wittenberg, & Reis, 1988), Social problem-solving inventory-revised (SPSI-R; D'Zurilla, Nezu, & Maydeu-Olivares, 2002), and restricted expression in the Dimensional Assessment of Personality Pathology-Basic Questionnaire (DAPP-BQ; Livesley & Larstone, 2008). One study lifted a bespoke set of items (4) about emotional disclosure from a study by Bedard-Gilligan et al.'s (2012 (2012)). All the measures are listed in Table 1 below and a detailed review can be found in Appendix B.

*Table 1. Key study characteristics, design, and outcomes*

| Study Authors (Year) | N | Age mean (SD) | Sex (f/m; other) | Study design | Sample type and setting | Country | Ethnicity | Trauma measures | Trauma type | Comparison group | Outcome measures |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Belford et al. (2012) | 165 | 19.95 (1.92) | 106/59 | Cross-sectional | University students | USA | 78.2% Caucasian; 7.3% Asian; 3.1% as African American; 11.4% other ethnicity. | BBTS (betrayal trauma) | Low, medium, high betrayal trauma | No and low betrayal trauma | RHI (relationship quality: peer/mentor) |
| Bistricky et al. (2017) | 132 | 35.7 (12.2) | 114/18 | Cross-sectional | Community | USA | 87.1% White; 5.3% Other/Biracial; 2.3% African American; 2.3% Asian/Pacific Islander; 2.3% Hispanic; and 0.8% Native American. | THQ (trauma) | Interpersonal trauma | NA | ECR-S (attachment) ICQ (interpersonal competence) |
| Fowler et al. (2013) | 705 | 33.9 (14.4) | 362/343 | Cross-sectional | Psychiatric hospital inpatients | USA | 91% Caucasian; 5% multiracial; 1% Asian; 7% African American. Additionally, 4% identified as Hispanic or Latino ethnicity. | THS (trauma) | All interpersonal trauma | Non-interpersonal trauma | RQ (attachment) |
| Huang et al. (2020) | 162 | 22.57 (3.46) | 111/51 | Cross-sectional | Community | Taiwan | N/R | TLEQ (trauma) | Interpersonal trauma | Non-interpersonal trauma | RAAS (attachment) |
| Jaffe et al. (2019) | 453 | 21.71 (2.23) | 100% female | Longitudinal | Community | USA | 60.7% European American; 35.8% African American; 5.5% Latina, 4.2% Asian; 3.3% American Indian; and 2.4% as other (multiple ethnicities could be endorsed) | LEC (trauma) | Interpersonal trauma | Non-interpersonal trauma | LEC (Revictimisation) RTO scale in PMBS (trust) |
| Kobayashi et al. (2021) | 206 | 25 (4.9) | 100% female | Cross-sectional | Community: specialist survivor services | USA | 63% Caucasian; 25% African American; 5% Latina; 7% biracial other. | SVAWS (gender violence) | IPV | NA | PAAQ (attachment to primary caregiver) ASQ (romantic attachment) WMCI (prenatal representations) |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Kolk et al. (2021) | 453 | 4 (0.88) <20; 20-29: 119 (26.27); 30-39: 297 (65.56); ≥40: 33 (7.28). Recruitment: 16 and above. | 100% female | Cross-sectional | Community (maternity service) | U.K. | 55.41% White; 30.24% Black African/ Caribbean or Black British; 4.19% Asian/Asian British19; 3.97% Mixed/Multiple ethnic groups; 6.18% Arab/Other ethnicity. | Lifetime trauma composite measurement | Interpersonal trauma (physical, sexual, IPV) | No interpersonal trauma | PBQ (infant bonding) Relationship and cohabitation status |
| Lathan et al. (2021) | 138 | 32.1 (11.5) | 100% female | Cross-sectional | Primary care clinic patients | USA | 89.1% Black; 5.8% White; 3.6% Multiracial; 0.7% Native Hawaiian/Pacific Islander | Modified TLEQ | Interpersonal trauma (moderate or high betrayal) | No interpersonal trauma | The seven-item betrayal subscale of the TAQ GTS (trust) |
| Reich et al. (2015) | 105 | 36.94 (12.68) | 100% female | Cross-sectional | Community | USA | 50.5% Caucasian; 39.0% African American; 1.9% Hispanic; 1.9% Asian; 1% African; 4.8 Bi-racial; 1% Did not respond. | Criterion A CTS-2 PMWI-SF | IPV | NA | SPSI-R (social problem solving) |
| Sandberg et al. (2010) | 224 | 21.73 (5.89) | 100% female | Cross-sectional design | University students | USA | 13% African American; 30% Caucasian; 27% Asian; 15% Hispanic; 12% other; and 2% unspecified | TLEQ | IPV and sexual victimisation | NA | ECR (attachment) |
| Sandberg et al. (2022) | 169 | 19.27 (2.40) | 125/44 | Cross-sectional design | University students | USA | 9% African American/Black; 25% Asian; 39% Hispanic/Latino; 10% White; 18% mixed or other. | LEC-5 (life events) | Interpersonal trauma | Non-interpersonal trauma | ECR-R (attachment) |
| Torres et al. (2013) | 369 | 38.9 (10.2) | 100% female | Cross-sectional design | Clinical and community: outpatient vs GP | Spain | Not Reported | ISA (spousal abuse) | IPV | Non-interpersonal trauma | DAPP-BQ (Suspiciousness, Restricted Expression, Rejection, Intimacy Problems) |
| Wiltgen et al. (2015) | 414 | 34 | 258/161 | Cross-sectional | Psychiatric hospital inpatients | USA | 89.6% Caucasian, 6.3% multiracial, 1.7% African American, 1.4% Asian, .5% American Indian or Alaskan Native, .5% or | SLESQ (life events) | Interpersonal trauma | NA | RQ (attachment) |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | Native Hawaiian or other Pacific Islander. Additionally, 7.5% identified as Latina/o. | | | | |
| Woodhouse et al. (2018) | 258 | 37 | 231/258 | Cross-sectional | Community | U.K. | Caucasian (n=258) | PDS (traumatic event list) | Interpersonal trauma | Non-interpersonal trauma | 6 items from SAQ (social acknowledgement) Emotional disclosure (4 items) RQ (attachment) |
| Wright et al. (2010) | 259 | 19.58 (1.05) | 100% female | Cross-sectional | University students | USA | 79% White, 6% African American, 5% Asian American, 5% Latina, 4% Multiracial; 1% did not report. | APA (partner abuse) SES (sexual abuse) | Sexual and nonsexual trauma group | Nonsexual trauma, and no trauma group | Subscales of safety, trust, and intimacy in TSIB (schemas) |

*Note*. Trauma measures: APA = Adult Physical Assault Scale is 12-items from the Abusive Behavior Inventory (ABI; Shepard & Campbell, 1992); BBTS = The Brief Betrayal Trauma Survey (Goldberg & Freyd, 2006); Criterion A of semi-structured IPV interview (American Psychiatric Association, 2000); CTS-2 = Revised Conflict Tactic Scales (Straus, Hamby, Boney-McCoy, & Sugarman, 1996); ISA = Index of Spouse Abuse (Hudson and McIntosh 1981); LEC = Life Events Checklist (Gray, Litz, Hsu, & Lombardo, 2004); LEC-5 = Modified Life Events Checklist for DSM-5 (Weathers et al., 2013); Lifetime trauma composite measurement generated by researchers at King's College London (Lockwood Estrin et al., 2019) using the Composite Abuse Scale-short version (CAS(S) pregnancy version, the Posttraumatic Stress Disorder Scale (PDS®) and the Structured Clinical Interview DSM-IV Axis PTSD module (First et al., 2002); PDS = PTSD diagnostic scale (Foa, Cashman, Jaycox, & Perry, 1997); PMWI-SF = Psychological Maltreatment of Women Inventory-Short Form (Tolman, 1999); SES = Sexual Experiences Survey (Koss & Gidycz, 1985); SLESQ = Stressful Life Events Screening Questionnaire (Goodman et al., 1998); SVAWS = The Severity of Violence against Women Scales (Marshall, 1992); THQ = Trauma History Questionnaire (Green, 1996); TLEQ = Traumatic Life Events Questionnaire (Kubany et al., 2000); THS = Trauma History Screen (Allen et al., 1999). Outcome measures: ASQ = Attachment Style Questionnaire (Feeney et al., 1994); DAPP-BQ = Dimensional Assessment of Personality Pathology – Basic Questionnaire (Livesley & Larstone, 2008); ECR = Experiences in Close Relationships Inventory (Brennan et al., 1998); ECR-R = Experiences in Close Relationships-Revised (Fraley et al., 2000); ECR-S = Experiences in Close Relationship Scale-Short Form (Wei et al., 2007); Emotional disclosure 4 items from (Bedard-Gilligan et al., 2012); GTS = General Trust Scale (Yamagishi & Yamagishi, 1994); ICQ = Interpersonal Competence Questionnaire (Buhrmester, Furman, Wittenberg, & Reis, 1988); LEC = Life Events Checklist (Gray, Litz, Hsu, & Lombardo, 2004); PAAQ = Perception of Adult attachment questionnaire (Lichtenstein & Cassidy, 1991); PBQ = Postpartum bonding questionnaire (Brockington et al., 2001); RHI = Relational Health Indices (Liang et al., 2002); RTO = Reliability and Trustworthiness of Others subscale in the Posttraumatic Maladaptive Beliefs Scale (PMBS; Vogt et al., 2012); RQ = Relationship Questionnaire (Bartholomew & Horowitz, 1991); RAAS = Revised Adult Attachment Scale (Collins, 1996); SAQ = Social Acknowledgement Questionnaire (Maercker and Müller's, 2004); SPSI-R = Social problem-solving inventory-revised (D'Zurilla et al., 2002); TAQ = Traumatic Appraisals Questionnaire (DePrince et al., 2010); TSIB = Traumatic Stress Institute Belief Scale–Revision L (Pearlman, 1996); WMCI = The Working Model of the Child Interview (Zeanah, Benoit, Barton, & Hirschberg, 1996); NA, not applicable; NR, not reported.

*Table 2. Quality Appraisal of Studies Included in the Review*

| Authors (year) | 1. Question clear | 2. Population defined | 3. Eligibility 50%? | 4. Inclusion/exclusion criteria | 5. Sample size, power | 6. Exposure measured before outcome | 7. Timeframe | 8. Exposure levels | 9. Exposure measure valid/reliable | 10. Exposure assessed over time | 11. Outcome measure valid & reliable | 12. Blinding | 13. Lost to follow up | 14. Confounding | Quality rating |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Belford et al. (2012) | Yes | Yes | Yes | Yes | No | No | CD | Yes | Yes | No | Yes | Yes | NA | Yes | Fair (9) |
| Bistricky et al. (2017) | Yes | Yes | Yes | No | No | No | CD | Yes | Yes | No | Yes | Yes | NA | No | Fair (7) |
| Fowler et al. (2013) | Yes | Yes | Yes | Yes | No | No | CD | Yes | Yes | No | Yes | Yes | NA | No | Fair (8) |
| Huang et al. (2020) | Yes | Yes | No | Yes | No | No | CD | Yes | Yes | No | Yes | Yes | NA | Yes | Fair (8) |
| Jaffe et al. (2019) | Yes | Yes | Yes | Yes | No | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Good (13) |
| Kobayashi et al. (2021) | Yes | Yes | Yes | Yes | No | No | CD | NA | Yes | No | Yes | Yes | Yes | Yes | Fair (9) |
| Kolk et al. (2021) | Yes | Yes | Yes | Yes | No | Yes | CD | Yes | CD | No | Yes | NR | Yes | Yes | Fair (8) |
| Lathan et al. (2021) | Yes | Yes | Yes | Yes | No | No | CD | Yes | Yes | No | Yes | Yes | NA | No | Fair (8) |

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Reich et al. (2015) | Yes | Yes | Yes | Yes | No | No | CD | Yes | Yes | No | Yes | Yes | NA | No | Fair (8) |
| Sandberg et al. (2010) | Yes | Yes | No | Yes | No | No | CD | Yes | Yes | No | Yes | Yes | NA | Yes | Fair (9) |
| Sandberg et al. (2022) | Yes | Yes | Yes | Yes | No | No | CD | Yes | Yes | No | Yes | Yes | NA | Yes | Fair (9) |
| Torres et al. (2013) | Yes | Yes | Yes | Yes | No | No | No | Yes | Yes | No | Yes | No | Yes | Yes | Fair (9) |
| Wiltgen et al. (2015) | Yes | Yes | Yes | Yes | No | No | CD | Yes | Yes | No | Yes | Yes | NA | No | Fair (8) |
| Woodhouse et al. (2018) | Yes | Yes | Yes | Yes | No | No | CD | NA | Yes | No | No | Yes | NA | No | Fair (6) |
| Wright et al. (2010) | Yes | Yes | Yes | Yes | No | No | CD | Yes | Yes | No | Yes | Yes | NA | No | Fair (8) |

*Note.* CD, cannot determine; NA, not applicable; NR, not reported; Quality ratings are good, poor and fair, and are determined following answers to the following 14 criteria: 1. Was the research question or objective in this paper clearly stated? 2. Was the study population clearly specified and defined? 3. Was the participation rate of eligible persons at least 50%? 4. Were all the subjects selected or recruited from the same or similar populations (including the same time period)? Were inclusion and exclusion criteria for being in the study prespecified and applied uniformly to all participants? 5. Was a sample size justification, power description, or variance and effect estimates provided? 6. For the analyses in this paper, were the exposure(s) of interest measured prior to the outcome(s) being measured? 7. Was the timeframe sufficient so that one could reasonably expect to see an association between exposure and outcome if it existed? 8. For exposures that can vary in amount or level, did the study examine different levels of the exposure as related to the outcome (e.g., categories of exposure, or exposure measured as continuous variable)? 9. Were the exposure measures (independent variables) clearly defined, valid, reliable, and implemented consistently across all study participants? 10. Was the exposure(s) assessed more than once over time? 11. Were the outcome measures (dependent variables) clearly defined, valid, reliable, and implemented consistently across all study participants? 12. Were the outcome assessors blinded to the exposure status of participants? 13. Was loss to follow-up after baseline 20% or less? 14. Were key potential confounding variables measured and adjusted statistically for their impact on the relationship between exposure(s) and outcome(s)

## Quality appraisal

No studies were excluded following rating with NIH Study Quality Assessment Tools (National Institutes of Health, 2014). However, the tool was used to explore and investigate the quality of the studies included in this review. It supported the researcher to find out more about the studies' design, use of measures etc… In doing so, methodological issues of the literature were revealed. These are considered in the discussion and serve to inform recommendations for future research.

All but one study were rated as fair (13). This was due to their correlational designs which made it difficult to establish causality. Only one longitudinal study was rated as good and looked at multiple time points, thus providing more robust evidence for causality (Jaffe et al., 2019).

### *Population and Recruitment*

Studies clearly stated their hypothesis and provided comprehensive descriptive information about study populations. Only two community studies recruited participants from different settings, thus increasing the risk of additional unmeasured confounds (Bistricky et al., 2017; Reich et al., 2015).

### *Exposure to interpersonal trauma*

The exposure measurement tools varied substantially ranging from a single self-report measure (n=12) to bespoke/multiple assessment tools (n=3). Studies considered exposure levels through number and type traumas, and relationship to the perpetrator, but only one study reported the time since the exposure (Torres et al., 2013). Therefore, it cannot be ascertained whether the timeframe was sufficient to notice an association, increasing the risk of bias.

### *Relational functioning outcomes*

All outcomes were measured with validated and reliable tools except for one (i.e., emotional disclosure; Woodhouse et al., 2018). The latter (Woodhouse et al., 2018) as well as two other studies, selected and reported only one of the subscales of their measure therefore increasing the risk of bias (i.e., avoidant attachment; Bistricky et al., 2017; i.e., betrayal; Lathan et al., 2021).

### *Power and design*

Several studies capitalised on large cohort data and routine outcomes (Fowler et al., 2013; Wiltgen et al., 2015) but none appeared to consider power calculations prior to recruitment. They all seemed to use convenience sample without justification, though this was commented on in the discussion by some.

### *Blinding*

All but two studies used self-report measures to assess exposure and outcome (Kobayashi et al., 2021; Reich et al., 2015), reducing the risk of bias relating to assessors' blinding.

### *Confounding variables*

Only seven studies collected data to determine the impact of confounding variables. These variables ranged from sociodemographic characteristics (n=6) to mental health symptoms (n=2) and trauma (n=2). A more detailed summary of the quality assessment can be found in the Appendix C and in Table 2.

## Narrative synthesis

Eight papers studied populations exposed to non-specified interpersonal trauma (Table 1), five looked at IPV and/or sexual trauma, and two used betrayal trauma categories (high or moderate) to determine interpersonal trauma exposure.

The IPV survivor studies examined the consequences of victimisation on internal representations for three relational levels (caregiver, romantic partner and infant) of attachment and bonding (Kobayashi et al., 2021), and on general attachment dimensions relating to partners (Sandberg et al., 2010). They also considered disruption of schemas through group comparison with non-interpersonal trauma (Torres et al., 2013), or amongst sexual, non-sexual (e.g., physical) and no trauma groups (Wright et al., 2010). The later did not specify recruiting only IPV, rather it categorised survivors using physical assault and sexual experience scale, both which are used in IPV.

The seven interpersonal trauma studies examined relational functioning mainly through attachment patterns including bonding, and through revictimisation. The betrayal trauma studies looked at relationship quality (Belford et al., 2012), betrayal and trust (Lathan et al., 2021).

We synthesised the broad range of relational functioning patterns in the following four themes by i) attachment dimensions and categories; ii) impact of interpersonal trauma on relationships, iii) beliefs about others; and iv) behaviour.

***Relationship Between Interpersonal Trauma and Attachment***

Seven studies investigated general patterns of attachment and all but one study (Huang et al., 2017) found significant associations between interpersonal trauma and an insecure attachment dimension or category. The literature greatly varied, and some studies only found associations between exposure to interpersonal trauma and an increase in attachment anxiety, (2) others with an increase in avoidance (2), one both, and one in fearful attachment.

In Sandberg et al.'s first (2010) mediator study, female university student survivors of IPV and sexual victimisation reported a positive and significant bivariate correlation with the anxious attachment dimension as assessed by the ECR. They found no association

between non-interpersonal trauma and attachment. In a recent study also recruiting university students and using a similar design and setting (albeit in a mixed gender sample) with a variant of the same measure (ECR-R), Sandberg et al. (2022) were able to partially replicate findings. They found an association of interpersonal trauma and non-interpersonal trauma groups with dimensions of attachment anxiety, but not avoidance. It is worth noting this study did include survivors who had experienced traumas as both child and adult.

Others have shown similar effects of interpersonal trauma and attachment anxiety and avoidance. A Taiwanese study (Huang et al., 2017), also found higher levels of attachment anxiety (measured with the RAAS) to be reported in the interpersonal group when compared to the non-interpersonal group. Unfortunately, this relationship was not significant, perhaps due to cultural differences (Shen, 2009). Huang et al. (2017) suggest that attachment anxiety interferes with Taiwanese cultural values of interpersonal harmony maintained through strategies of forebearance (Wang, 2008) and this may attenuate this association.

Not all studies with attachment patterns as an outcome found an association with the anxious dimension. The results of a large psychiatric study (Wiltgen et al., 2015) using routine outcomes suggest a significant positive correlation between interpersonal trauma and attachment avoidance but not anxiety (RQ). As such they contradict the results reported thus far. The inpatient population levels of interpersonal trauma as measured by SLESQ were high, with 60% experiencing more than across lifetime, and nearly 40% three or more different types which is more frequent than community or student population. A third reported physical abuse in childhood.

Another study found a significant association between interpersonal trauma and attachment avoidance, though Bistricky and colleagues (2017) only included the avoidance

subscales in their planned analysis, providing no information on whether a similar correlation would be found for attachment anxiety.

The study with the largest sample found (705 participants) found positive and significant associations between both insecure attachment dimensions and interpersonal trauma (Fowler et al., 2013). This study collected routine outcomes from the same psychiatric inpatient hospital to Wiltgen et al's and used the same attachment outcome measure (RQ).

Lastly, Woodhouse et al. (2018) found a significant association between interpersonal trauma and the fearful avoidant insecure attachment style in a community sample. The terminology here used reflects the categorical rather than the dimensional conceptualisation of attachment (Figure 1). Fearful style combines elements from both dimensions, seeking to avoid intimacy and close relationships to minimise disappointment whilst also showing a need for dependency on others to maintain a positive self-regard (Bartholomew & Horowitz, 1991). As such, Woodhouse et al's findings (2018) showing an association to an attachment category that combines both anxiety and avoidance are seemingly aligned with those of Fowler's who found high levels of attachment anxiety and avoidance.

In summary, two studies found links between trauma and anxious attachment, two with avoidant attachment, one both and one fearful. The above evidence suggests there is a link between the experience of interpersonal trauma and insecure attachment styles leading survivors to develop internal representations of others as "unreliable and rejecting instead of trustworthy and available" (Bartholomew & Horowitz, 1991).

***Impact of Interpersonal Trauma on Relationships***

Three studies examined participants' interpersonal functioning in their existing and future relationships. One study was longitudinal and focused on revictimisation (Jaffe et

al., 2019). Two studies looked at prenatal representations and parental bonding (Kolk et al., 2021) or specific attachment relationship (Kobayashi et al., 2021). The latter was included here as it went beyond the scope of general attachment patterns by aiming to develop an intergenerational model of attachment in which childhood and current (e.g., to romantic partner) working models affected maternal prenatal representations, thereby bringing together three generations.

In Kobayashi's study (2021), IPV was found to be directly related to prenatal representations and insecure romantic attachment, and insecure attachment to the romantic partner was directly related to quality of prenatal representations as assessed respectively by the Attachment Style Questionnaire (ASQ; Feeney, Noller, & Hanrahan, 1994) and the Working Model of the Child Interview (WMCI; Zeanah & Benoit, 1995). These findings raise questions about whether interpersonally traumatic experiences like IPV can impact the formation of new attachment representations and perhaps may revise older internal working models. A study by Kolk et al. (2021) did not find a similar relationship between trauma and parental bonding with newborn children at three months: lifetime trauma was not significantly associated with self-reported scores on the Postpartum bonding questionnaire (PBQ; Brockington, Fraser, & Wilson, 2006).

One of the longitudinal studies (Jaffe et al., 2019), found a direct effect of past interpersonal trauma on a subsequent interpersonal trauma a year after the first wave of measures. A history of interpersonal trauma was associated with a significant increase in risk for revictimisation as assessed by the LEC (Life Events Checklist; Gray, Litz, Hsu, & Lombardo, 2004). They did not find any significant associations for relationship status change. By contrast, Kolk and colleagues (2021) found women with experiences of lifetime trauma were significantly more likely to be single and not to live with a partner even within the maternity context.

With regards to non-romantic relationships, one study of university students (Belford et al., 2012) found a significant negative association between high betrayal traumas (i.e., where low betrayal trauma equates non-interpersonal trauma and high betrayal trauma is interpersonal trauma) and an individual's perception of relationship quality, specifically the community scale though not the friend and mentor one. The relational health index (RHI; Liang et al., 2002) does not compare these scores with subscales about friends and family which could have provided a richer comparison. In fact, difficulties with community also appeared to arise in the form of a negative association between interpersonal trauma and social recognition and disapproval in the Social Acknowledgement scale (SAQ; Maercker & Müller, 2004) (Woodhouse et al., 2018).

In sum, interpersonal trauma such as IPV was found to impact the formation of attachment representations (Kobayashi) and increase the risk of revictimisation (Jaffe et al., 2019). Women with lifetime trauma were more likely to be single and not live with a partner (Kolk et al., 2021) and survivors of high betrayal traumas community relational health was lower (Belford et al., 2012).

***Beliefs about Others: Trust, Betrayal, Intimacy and Safety***

Four studies looked at the relationship between interpersonal trauma and trust, and all but one (Lathan et al., 2021) found significant results. In one study (Torres et al., 2013), mistrust of others was conceptualised as suspiciousness involving: "*hyperalert to signs of trickery or harm; searches for hidden meanings in events; questions others' loyalty; often feels persecuted*" (DAPP-BQ) (Livesley & Larstone, 2008). A relationship was found where severity of IPV was predictive of suspiciousness.

These findings are supported in a study comparing sexual trauma with no trauma groups, where the sexual trauma group had relatively greater disruption of schema around trusting others in the Traumatic Stress Institute Belief Scale–Revision (TSIB; Pearlman,

1996) (Wright et al., 2010). There was also another comparison of interpersonal vs non-interpersonal trauma where there was a significant association between group membership concerns about the Reliability and Trustworthiness of Others subscale in The Posttraumatic Maladaptive Beliefs Scale (PMBS; Vogt, Shipherd, & Resick, 2012) (Jaffe et al., 2019). Across IPV, sexual trauma and general interpersonal trauma group membership was associated with a decrease in trusting others, even when findings were not significant (Lathan et al., 2021). The poor internal consistency of the measure used (α= .53) – the General Trust Scale (GTS; Yamagishi & Yamagishi, 1994) – renders the results produced by this outcome questionable. A decrease in trust was not limited to others, self-trust disruptions were also significantly associated with sexual trauma (Wright et al., 2010) and to an extent in interpersonal trauma (Jaffe et al., 2019). Jaffe et al. found an association with the Self-Worth and Judgment subscale in the PBMS (Vogt et al., 2012) which captures an individual's trust in themself (e.g., "I trust my own judgment"). Beyond not trusting others, sexual trauma (Wright et al., 2010) and interpersonal trauma (Lathan et al., 2021) were also associated with a significant lower sense of safety with others, especially with greater cumulative or frequency of trauma exposure (Lathan et al., 2021).

Though betrayal was often included as an event related factor where it determined the type of interpersonal trauma and therefore group allocation, one study also examined betrayal appraisals. They found that cumulative trauma (i.e., exposure to more types of interpersonal trauma) and exposure to high betrayal and moderate trauma ( i.e., the experience of victimisation by a close other or a stranger respectively) led to significantly increased posttraumatic appraisals of betrayal in the TAQ (Lathan et al., 2021).

Sexual trauma and IPV were significantly associated with greater intimacy problems about avoiding attachment, intimacy or inhibited sexuality (DAPP-BQ) (Torres et al., 2013) or schema disruptions about not wanting to be alone or having people with

whom to feel close and connected (TSIB) (Wright et al., 2010). Relational difficulties extended also into the realm of rejection: IPV victims scored lower than controls on the Rejection subscale which was defined as a more hostile and aggressive; and a more dominant, judgmental and rigid cognitive style (DAPP-BQ), with length of time being associated with even lower scores (Torres et al., 2013).

In sum, studies found that interpersonal trauma, such as sexual trauma or IPV, was associated with decreased trust in others and the self, disrupted sense of safety, increased posttraumatic appraisals of betrayal, and relational difficulties including avoidance of intimacy, inhibited sexuality, and a more hostile and aggressive cognitive style.

### Impact on Interpersonal Behaviour

Four studies looked at behavioural problems. One study found that experience of IPV was significantly associated with avoidance problem solving (Reich et al., 2015), and another with avoidance of emotional situations and self-disclosure (i.e., Restricted Expression; Torres et al., 2013). Self-disclosure was also found to be reduced in another study of interpersonal trauma (Woodhouse et al., 2018) looking at a bespoke number of questions. One study (Bistricky et al., 2017) found that although interpersonal trauma frequency did not have direct effects on interpersonal competence, indirect effects of trauma type worked through attachment avoidance to impact interpersonal competence. To conclude, interpersonal trauma was associated with behavioural avoidance, decreased self-disclosure and indirectly interpersonal competence.

## Discussion

### Overview of Findings

Studies on adult interpersonal trauma and interpersonal functioning were reviewed and synthesised to get a broad understanding of survivors' interpersonal functioning

following exposure to interpersonal trauma. The findings and methodological issues of this review were summarised, before considering its research and clinical implications.

The literature reviewed supports the idea that exposure to adult interpersonal trauma is correlated with relational functioning difficulties. Across papers, the event of interpersonal trauma or its experience was linked to insecure attachment styles, schema disruptions, and behavioural difficulties across a range of contexts (romantic, infant, community etc.). However, definite conclusions from the data could not be drawn given the significant methodological issues across studies, notably the over reliance on convenience sample, inconsistent self-report measurement tools, cross-sectional designs and correlational data, and the unknown role of third variables.

All but one study (Huang et al., 2017) found significant associations between interpersonal trauma and an insecure attachment dimension or category. Studies described survivors either drawn to dependency/seeking others (anxious attachment) or evading close intimacy (avoidant attachment). Internal representations of others are known to determine how we relate to them and the associated behavioural strategies (Scarvalone et al., 2005). The reviewed literature showed how avoidance was not only measured and recorded in terms of attachment dimension but also behaviourally through avoidant problem-solving strategies, avoidance of emotional situations, and difficulties with self-disclosure (Reich et al., 2015; Torres et al., 2013; Woodhouse et al., 2018).

It was found that survivors struggled to feel safe, were less trusting of others and themselves (Jaffe et al., 2019; Lathan et al., 2021; Wright et al., 2010), and had elevated post-traumatic cognitions of betrayal (Lathan et al., 2021), thus supporting the hypothesised relationship between interpersonal traumatic experiences and schema disruptions (Everly Jr & Lating, 2004; McCann et al., 1988). Exposure to this trauma type and the disruptions that ensued also manifested in difficulties around being intimate with

others, ranging from avoiding closeness to not wanting to be alone (Torres et al., 2013; Wright et al., 2010) and rejection which was characterised by hostility and dominance (Torres et al., 2013).

The evidence suggests that interpersonally relevant schemas such as safety, trust and intimacy were disrupted as the experience was generalised and psychological adaptations were made (Patricia A. Resick et al., 2017). This is in line with McCann and colleagues' (1988) understanding that trauma exposure leads to overaccommodation of core beliefs. These altered schemas, through their influence on an individuals' understanding and actions (Scarvalone et al., 2005), may then directly or indirectly lead to interpersonal unhelpful behaviours. It can be understood that considering the lack of safety, trust and intimacy that survivors experience, they may find it hard to self-disclose information (Torres et al., 2013; Woodhouse et al., 2018), even more so in light of the perceived betrayals (Lathan et al., 2021). These findings can be used to start delineating how schemas, mental internal representations and behaviour may be interrelated with avoidant coping, leading to emotional numbing which is associated with higher intimacy issues (Birkley, Eckhardt, & Dykstra, 2016) or with anxious attachment through a fear of abandonment and hypervigilance to threat (Mikulincer & Shaver, 2007). When we consider the evidenced schema disruptions, insecure attachments and behavioural strategies associated with exposure interpersonal, it is reasonable to assume that survivors' quality of relationships may be affected.

The review also provided evidence of how existing relationships had been impacted. Exposure to interpersonal trauma was associated with disrupted internal representations for mothers building relationships with their infants and women in their romantic relationship (Jaffe et al., 2019; Kobayashi et al., 2021; Kolk et al., 2021). This extended beyond intimate and familial relationships into lower relational quality with the community (Belford et al.,

2012). It was also linked to an increased risk of revictimisation which notably was reported alongside lower levels self and other trust (Jaffe et al., 2019).

Although rare, studies have started to consider the relationship between internal working models of attachment and schema, identifying schemas (e.g., beliefs and attitudes) as useful conscious elements of attachment which may be the target of intervention and modify behavioural strategies (Platts, Mason, & Tyson, 2005). It is reasonable to wonder about how the interpersonal difficulties here reviewed overlap, differ and may interact with one another depending on the theoretical framework in which they are considered whether it be attachment or schema. Developing a model is beyond the scope of this review. These findings begin to paint a picture of these interrelations and raise questions about direction and reciprocal feedback loops between trauma, functioning and relational quality, experiences and events (e.g., violence).

**Limitations**

Only a small number of papers met the inclusion criteria for this review. Numerous studies were excluded because they failed to report on and differentiate between adult and child interpersonal traumatic experiences, highlighting the research bias in favour of investigating the impact of childhood trauma. Included studies that relied on student population, especially younger undergraduate subjects, may still contain a sample predominantly traumatised in childhood, leading to overall results that are not entirely representative of the specific effects of adult trauma. Unfortunately, many studies did not control for age at time of trauma event (Bistricky et al., 2017). This is a significant issue as there has been a historical focus on the relational sequelae of childhood trauma on relationships and less attention paid to trauma occurring during adulthood. The literature also seemed to reflect a preference for diagnostic predictive models (e.g., how interpersonal variables influence depression severity) as opposed to fundamental research.

Studies overreliance's on retrospective self-reported data, made them susceptible to recall bias and demand effects. Due to the studies' cross-sectional design causation could not be determined nor the direction of the relationship between the variables examined. Concretely, this meant that in some studies' authors hypothesised interpersonal difficulties to be a consequence of traumatic exposure whilst in others they suggested it was an antecedent. Without prospective evidence the direction of the association cannot be ascertained and all that can be shown is that individuals exposed to adult interpersonal trauma struggle significantly with a range of interpersonal difficulties, including risk for revictimisation.

A limitation to synthesising the evidence is the breadth of measurement tools used for the same constructs and theoretical conceptualisation of overlapping difficulties such as attachment dimensions and schemas. Many studies used validated tools, but some relied on a limited number of items from scales or questionnaires. Evidence for each interpersonal item was limited to only a few studies, demonstrating the lack of research in the area. The variety of settings and populations as well as the underreporting and analysis of key demographics and confounding variables yields a literature with findings that are insufficiently robust, broad and lacks comparability.

**Future Research**

One study suggests that the perception of betrayal in a relationship with a perpetrator has a more significant impact than the event itself (Lathan et al., 2021). The review highlights a need for more research into the relational consequences of interpersonal trauma and the mechanisms behind it. Future studies should aim to understand the relationship between trauma and post-traumatic appraisals, disturbances in relationships, and potential changes in attachment style, and perhaps develop a model of the relationship between trauma and interpersonal functioning. The field would benefit

from more robust evidence, a clear definition of constructs, and a consistent approach to measurement. A developmental research approach would track attachment from infancy to adulthood after trauma, including variables such as exposure type, experience, frequency, age of onset. It would also include a global and inclusive population vis a vis social graces, socio-economic status (Bauer, 2019) and recruitment setting (community over university students). There is a need for transparent and reliable research (Munafò et al., 2017) that includes confounding variables that may account for the findings detailed in this review.

**Clinical Implications**

The insecure attachment styles and alterations to foundational beliefs about trust and safety in relation to others detailed in this review are active elements that could disrupt the therapeutic relationship (Safran, 1990). Good therapeutic alliance is crucial to the effectiveness of interventions, particularly post-trauma symptomology (Howard, Berry, & Haddock, 2022), and therefore great care should be taken in addressing these interpersonal consequences in therapy. This may be worthwhile considering for all survivors seeking treatment irrespective of diagnosis, considering many will seek treatment for non-trauma specific disorders (e.g., depression, anxiety). The choice of therapeutic approach (e.g., schema or psychodynamic) and its objectives may also be influenced. Findings from a study about cognitive processing therapy (Patricia A Resick & Schnicke, 1992) suggest that the cognitive restructuring of disrupted schemas element was more effective at symptom reduction than exposure (CPT; Resick et al., 2008). Knowing which schemas present the most salient consequences in survivors of interpersonal trauma will help clinicians direct their therapeutic interventions (Wright et al., 2010).

Considering the hypothesised increased vulnerability for revictimisation and impact on relationship quality in a variety of contexts, it seems important to directly address insecure attachment styles, schemas and behaviours to invest in the long-term safety and

relational satisfaction of the client. Supporting good interpersonal functioning is key to positive health outcomes long term and recovery (Wang et al.,2018).

## Conclusion

In conclusion, this review found an association between exposure to interpersonal trauma and disruptions to interpersonal functioning across attachment, schema, behaviour and specific relationships. Future research needs to address major methodological concerns, refine measures/constructs, and improve understanding of the mechanisms by which these associations take place and influence the quality and quantity of relationships. Considering the importance of relationships for good health outcomes, future interventions should be tailored to supporting survivors interpersonally beyond diagnosis and within the therapeutic relationship.

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**Service Improvement Project (SIP)**

# Mapping the needs of special guardianship kinship carers order (Attach team Oxfordshire)

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**Abstract**

Research suggests that special guardian order (SGO) kinship carers for children have fewer personal resources, face increased challenges/responsibilities/demands and yet receive less support from services than other carers. This impacts their well-being as well as the stability of placements. Carers cannot meet the needs of the child and their own needs without support. We consider Bronfenbrenner's bio-ecological model and aim to identify carers' unmet needs and the support they require for them to fulfil their role and realise their potential for effective functioning.

This service improvement project interviewed SGO kinship carers offered support by a local authority psychological service for adoptive, special guardianship and foster care families to identify their unmet needs when accessing the service in relation to the different layers of Bronfenbrenner's bio-ecological model.

An interview schedule was developed collaboratively with the service team. Qualitative data from 5 semi-structured interviews of 7 service users' experience was collated and analysed. A thematic analysis of the data showed that carers struggled to navigate services and access support, negotiate relationships in the new family structure, and care for children with complex needs in adversity. These challenges impacted on the carers' well-being and insufficient support was available to meet their needs. Recommendations to provide support that more adequately meets carers needs were developed, incorporating participants feedback and shared with the service along with findings. An implementation plan is being developed.

## Introduction

Special Guardianship Orders (SGOs) are formal court orders that give a carer – often a relative – responsibility and decision-making power for a child until their majority. These have become more common since their creation in 2002 and are thought to offer greater legal security, thus creating the foundation for a more permanent relationship. SGOs differ from Adoption Orders as children retain legal and relational links with birthparents, if appropriate, and from fostering as local authorities shed statutory obligations and children are removed from the care system. Unlike foster carers who receive a full package of care – including training -to meet the child's needs, SGO carers are only eligible for support if an assessment is recommended by the courts and/or the child was previously looked after by local authorities. This support which may include therapeutic services, mediation services with birth families, and financial support, is much less advantageous and comprehensive (Bowyer, Wilkinson, & Gadsby Waters, 2015; Harwin, Simmonds, Broadhurst, & Brown, 2019; Simmonds, Harwin, Brown, & Broadhurst, 2019).

In a Special Guardianship Review report (2015), carers criticised SGOs as a 'cheap option' fraught with misinformation. They raised issues with managing contact with birthparents, the availability of training and therapeutic help, the complexity of parenting and attachment needs and the lack of financial support. Separate research also shows that the social care currently provided to SGO families can be minimal and can suffer from insufficient time to adequately assess placement safety, and from a dearth of knowledge about the specific needs of SGO carers and their wards (Wade, 2014). This raises concerns about the long-term implications of SGO orders, just as their increased use creates a greater need for the provision of a tailored package of care that understands and meets the specific needs of this group.

A particular feature of SGOs is that many carers are known to the child and are a relative of the birthparents (also known as kinship carers). This pre-existing relationship is assumed to facilitate direct contact without mediation, yet existing research (Kiraly & Humphreys, 2016) shows that the power dynamics between birthparents and carers (e.g. grandparents) adds complexity to the relationship. Families often become kinship carers after the loss of a loved one, whether actual or perceived (e.g. incarceration, substance abuse, poor health), meaning substantial adjustments need to happen very suddenly. This can impact carers' well-being and available resources when they have been shown to have fewer personal and social resources from which to draw (Palacios & Jiménez, 2009). SGO carers, however, are provided with considerably less support than foster parents. Wade (2014) identifies clusters of concerns SGO carers have regarding managing contact with birth parents (and associated safety concerns) and responding to the complex emotional/behavioural needs of the children (often linked to placement breakdown). Separate research suggests carers feel conflicted about their new identity and uncertain about its social implications, and that their social and romantic relationships can be negatively impacted (Stobbs & Prowle, 2020). The findings indicate that carers can feel ill-prepared to deal with their new responsibilities and become overwhelmed, particularly considering the complex needs of those in their care.

This is an issue because research shows that without support, '*caregivers can become defensive, frustrated and with a sense of failure*', leading to the children interpreting these responses to mean '*they remain in danger*'(Golding, 2020, p.373). As highlighted in the literature about maltreated children (Houshyar, Gold, & DeVries, 2013; Maslow, 1954), children require a supportive and stable environment (and relationship with the caregiver) to develop effectively, especially considering the experienced losses, transitions, mental health and attachment difficulties. Since a stable and supportive relationship with the

caregiver depends on the overall well-being and mental health of the carer in question, interventions must consider the needs of the caregivers as well as the children's (Golding, 2020).

Research has shown that in order to effectively fulfil their role in mental health promotion for the children in their care, foster and kinship carers should be provided with a level of support which allows them to maintain good personal health and mental health (Dozier, Higley, Albus, & Nutter, 2002). Bronfenbrenner's bio-ecological model outlines the importance of systemic factors and layers of support through what is termed proximal processes – the interactions of the individual with persons, objects, and symbols – which are the primary mechanisms at play before individual characteristics, the latter only indirectly influencing through the impact of the proximal processes (Bronfenbrenner & Ceci, 1994). We can deduce from this that to address difficulties experienced by the individual, we need to look at the environment and notably improve the proximal processes to stabilise placements and help child and carer alike realise their potential for effective functioning. The different layers of proximal processes may progress from child to carer, wider family, community, schools and services, and finally society.

The research reviewed so far suggests supporting SGO caregiver well-being can have positive benefits for the children. We can further hypothesise that SGO carers who presently often lack support and resources might have unique needs that differ from those of adoptive and foster non-kinship carers. These needs may not be currently met or understood by local psychological services originally designed to support adoptive placements, and research in this area is only nascent. This project will therefore aim to improve our understanding of the unmet needs of the SGO carers within Attach service, a council psychological service for adoptive, special guardianship and foster care families.

### Question

What are Special Guardians' unmet needs when accessing the service in relation to the different layers of the ecological model:

a. Navigating and negotiating relationship with services (services)
b. Managing impact of SGO on romantic and social relationships (community)
c. Managing contact with birth parents (family)
d. Individual wellbeing (carer)
e. Parenting and responding to complex needs (child)
f. Other

How could the service meet the identified needs?

## Methods

### Design

This project relied on qualitative methodology, using individual semi-structured interviews and thematic analysis (Braun & Clarke, 2006). This approach was suitable for this project's scope as it permits exploration of individual views and needs of service users in the context of a small sample size. The project was reviewed by the local authority and granted ethical approval.

### Participants

Participants were recruited from the service by clinicians sharing an advert with them (from May 2021 until February 2022) and were self-selected.

a. *Inclusion criteria:*

i. SGO kinship carers

ii. Able to speak English and provide consent to take part in the study

iii. Have been referred to the service and are currently under their care

b. *Exclusion criteria:*

i. SGO non kinship guardians

Interviews took place online on Microsoft Teams due to Covid-19 restrictions. AM interviewed all participants and had no prior relationships with them.

10 carers expressed interest in an interview though some were unable to participate due childcare pressures in light of COVID-19 isolation rules. The final interview sample included 7 SGO carers in total across 5 families (see demographics Table 1 in Appendix F).

**Procedure**

A digital flyer (Appendix G) was used to recruit participants. Participants were then provided with an information sheet (PIS) explaining the procedure (Appendix H) before consenting to take part in the study either by completing an online MS form or giving verbal consent recorded on video (Appendix I). Informed consent, compensation, the right to withdraw, use of pseudonym, the PIS, the debrief email (Appendix J) are some of the steps taken to safeguard ethical considerations. Participants were sent a debrief email and advised to contact their clinician for support if needed. The procedure is detailed in Appendix K.

**Measures**

Based on our theoretical framework and the hypothesised needs and challenges of this population, we selected 6 areas to explore with possible questions. An interview schedule was produced collaboratively during a team consultation with professionals (e.g.,

psychologists, social workers) who reviewed and narrowed down questions (see Appendix L for the interview schedule). These were later finalised with external and internal supervisors. Unfortunately, the carers' busy schedules meant no expert by experience was available for research development.

**Data Analysis**

The semi-structured interviews were video recorded, transcribed verbatim and analysed thematically by the first author (AM) (Braun & Clarke, 2006). Data was analysed to identify initial codes with NVivo v12 (QSR International, QSR, 2012) for transparency and producing an audit trail. The interviews were reviewed altogether - including the feedback on Attach which was the context for this project and therefore the participants referenced more than once throughout the interviews. To ensure consistency between the ones coded first and last, any relevant data not previously identified was added. From these codes, themes were generated and discussed with a second coder (JA) who had read through two interview transcripts. Few discrepancies emerged pointing to good inter-rater reliability, and these were resolved. CN and JA examined transcript extracts and their themes to assess face validity. AM aimed to consolidate and reduce data by considering the validity of individual themes across all transcripts but also, developing memos and summaries against each theme. JA and CN agreed on the final themes.

I was aware of the context and discourse prevailing around SGOs which depicted families being let down by the system. This being a service improvement project, I also wanted to consider the position of the service needs around identifying problems and solutions to support service users perceived as 'hard to engage'. I was curious about the potential 'them' and 'us' dyadic tensions and sharing of responsibility/blame amongst the two parties. As a professional who has completed the intermediate systemic family therapy

training, I wanted to position myself outside this dyad as much as possible by letting the participants know that I was a researcher and that their contributions and participations would be entirely confidential. I encouraged them to share their anger and disappointment. In doing so, I hope to have given them permission to voice their negative feelings about the system and its injustices without fear of repercussion or judgement.

I invited personal biases and possibly stories of loss, resignation, and 'stuckness'. I was aware that in doing so I may be influencing the focus of the research as well as my interpretation of the data, especially in grouping themes. Whilst qualitative methods and especially thematic analysis stem from a constructivist and interpretativist approach, I was organised by the purpose of this project which is to better understand the needs of service users with a view to generate recommendations and improve the service. This meant that I felt a critical realist approach could be a helpful way to consider the data where I would assume that meaning is co-created by interviewer and interviewee. I hoped that in enlisting the help of an additional coder and using a methodological approach which sought for the analysis to seek greater objectivity, accuracy and reliability (Braun & Clarke, 2023), it would provide more robust data for practical service use by balancing some of the subjectivity of my voice with that of another researcher and coder. I therefore meant to attempt to be more scientifically descriptive and chose to include Braun and Clark's 2006 methodology which includes procedures such as a second rater for keeping bias in check.

## Results

Five superordinate themes emerged from the thematic analysis (see table below). The first three themes outline the key challenges that SGO carers face in their new caring position: navigating services, negotiating the new family structure and caring in adversity. The fourth theme summarises the unmet needs of the carer and the fifth their feedback on

Attach. Each theme is described below with its subordinate themes and illustrative quotes. Further evidence of each theme is shown in Appendix M.

**Table 2.** *Table of themes*

| Superordinate theme | Subordinate Theme |
|---|---|
| **1. Navigating services and help-seeking** | 1.1 Accessibility issues due to a complex system |
| | 1.2 Available support is inappropriate or insufficient |
| | 1.3 Support systems filling the gaps |
| **2. Negotiating new family structure and relationships** | 2.1 Naming the role |
| | 2.2 Managing the transition |
| | 2.3 Negotiating contacts |
| **3. The challenge of caring in adversity** | 3.1 Adversity as the context of the SGO and its imperative |
| | 3.2 Familial sacrifice as the solution |
| | 3.3 Caring for children with complex needs |
| **4. Impact on carer wellbeing and need for support themselves** | 4.1 No time to rest, no time for basic needs |
| | 4.2 Reduced access to social networks and intimate relationships (love and belonging) |
| | 4.3 Emotional burden and mental health needs (well-being and self-esteem) |
| **5. Feedback on ATTACH** | There were no subthemes |

### 1. Services and help-seeking

Conversations about support clustered around issues of accessibility in a complex system, lack of availability of appropriate support, and other services filling the gaps.

#### 1.1 Accessing support in a complex system

A challenge for carers was accessing support and navigating a complex system once the SGO had been granted. They struggled to locate the support they needed: *'[it was] hard to know what the different teams offer' (Emily & Rebecca), 'I don't know who to ask.'(Sarah)* and to know what to expect. Support was perceived as hard to access *('you shouldn't have to … beg for it' (Emily & Rebecca))* and to arrive too late when carers were struggling

*('something that's offered to people sooner, not when they get to a crisis point.' (Sarah))*. Interviews showed carers engaging and liaising with numerous services including legal, educational, mental health and social services, to access support, thus illustrating the fragmented nature of support pathways.

### 1.2 Formal support is inappropriate support

Carers were surprised at the lack of support post SGO. Granting of the SGO was seen as the reason for withdrawal of support from social services *('I lost my social worker straight away' (Emily & Rebecca))*, and lack of access to practical support such as respite *('if we had gone fostering or adoption, we might have been entitled to a little bit of respite.' (Laura))*. Carers used words like *('dropped' (Laura))* and expressions such as *('there is just nobody' (Steve & Terry))* to describe how the lack of available support made them feel abandoned.

They lamented the lack of peer support, of a place to share their experiences and have them normalised *('[know they're] going through similar stuff and what little tips they've got as to how they've dealt with issues', (Laura))*, but also a community.

### 1.3 Informal support systems filling the gaps

Family and schools filled the gaps by guiding carers to appropriate support whilst helping them until they received access.

Carers leaned on family and schools to provide adequate childcare and respite *('When they're at school we enjoy that bit of freedom' (Laura))*, *('The only person we've ever had support with childcare is Steve's mum.' (Steve & Terry))*. Schools were perceived

to guide access to a complex system *('[School] recommended CAMHS and Attach for me.' (Sarah)).*

When professional support became available, carers valued the reassurance *("I needed [ Attach] to let me know that I was basically doing alright' (Emily & Rebecca))* as well as sense of community *('It's nice to know that I'm not the only one' (Sarah)).*

**2. Negotiating new family structure and relationships**

Views about the new family structure and shifting relationships were grouped around three main themes: naming the role, managing the dynamics of the role transition, and managing contacts with birthparents.

**2.1 Naming the role**

Carers carefully negotiated naming their role according to their pre-existing relationship with the child, the needs of the latter and the birthparents, and the specifics of their interlocutor.

Several carers described expecting their role name to remain the same *('I've always been her Nan and I always will be', (Sarah)).* This was not self-evident to the children put in care as infants who called their carer 'mum' *('he says: my mum's the best', (Clara)).* Carers had to negotiate naming considering birthparents ('*she started calling me 'mummy' as well which upset her biological mum', (Steve & Terry))* and the recommendations of services around attachment *([Attach] 'advised us not to do that [correct the child when they called the carer mum] since she may end up feeling rejected', (Steve & Terry))*

Carers described varying confidence and openness when sharing their family situation with the community *('you just sort of mention a little bit more. It is sometimes*

*difficult', (Clara)).* This depended on the context of the interlocutor, whether a professional or an acquaintance *('I make it clear that I'm her Nan and guardian as well. I even put that on when I do letters for school', (Sarah)).*

**2.2 New dynamics - managing the role transitions**

A challenge of the transition was explaining the new caring arrangements considering their traumatic, abusive and sometimes criminal context*: "it's difficult 'cause you want to tell them, but you know you can't tell them" (Laura).*

Though some carers were already caring for the children ((*'they've actually been with us 2 1/2 years', (Laura)),* the legal transition shifted their relationship to the birthparents (e.g., from being their parent to their child's carer). This meant prioritising the needs of the child in their care: ('*it just makes it difficult because… we have to put the grandchildren above that relationship'), (Steve & Terry)).*

Carers reported bilateral communication difficulties with the child and issues separating relationships with birthparents from relationships with the children: *'because I was her Nan… she didn't want to set me against her mum' (Emily & Rebecca).*

**2.3 Negotiating contacts**

Families described difficulties managing contacts with birthparents once social services withdrew. This involved deciding if, how and when contacts took place based on legal, risk and psychological wellbeing factors relating to the child and the carer ('*She is obviously supervised with me or mum … he's using …you stopped him really from …having contact cause it was upsetting them', (Emily & Rebecca)).* The carers' new position as 'gatekeepers' affected their relationship with the birthparents: '*when I told him that contact*

*was stopping. It was horrific, the messages and* the *abuse I had', (Laura),* and led to difficulties with the children ('*I'm the bad nanny', (Laura)).* Carers missed social workers' involvement as they made *'a big difference in terms of dynamics and managing it.' (Steve & Terry)).*

Difficulties arose when there was more than one birthparent and their family involved. ('*there's also two dads involved… times that by lots of separated grandparents. There's about six different parties, (Steve & Terry)).* All birthparents were not present due to being either deceased, incarcerated or simply absent.

### 3. The challenge of caring in adversity

Caring in adversity clustered around three subordinate themes: adversity as the context of the SGO; the imperative to self-sacrifice in the face of adversity; and caring for children with complex needs.

### 3.1 Adversity as the context of the SGO

When discussing how the children ended up in their care, themes emerged around child neglect *('Mommy didn't feed them'(Laura)),* and exposure to adverse events including: parental substance abuse ('*their mother was a heroin addict'(Emily & Rebecca)),* suicide *('He took his own life' (Sarah)),* domestic violence *('domestic violencef'(Laura)),* and incarceration *('Dad is out of prison' (Clara)).*

### 3.2 Familial sacrifice as the solution

Carers deprioritised their needs to meet caring demands because of love for the children and felt familial responsibility. State-run care was considered unacceptable, leaving the family as the only acceptable solution, no matter the sacrifices*: 'we say what option have*

*we got?'(Laura), 'I would not have let them go outside the family.' (Emily & Rebecca).* Most carers gave up (at least one of) employment, homes, pensions and retirement travel plans. They hoped to achieve a positive outcome *('we just want to give them a better life' (Clara*)) once a new family structure was in place, however it was not as expected *('didn't go how I imagined it would go' (Sarah)).*

### 3.3 Caring for children with complex needs

Carers were overwhelmed by unanticipated consequences of the children's complex needs. Carers described problems around communication, soothing/attachment *('the only way she'd go to sleep is if you laid her down in her bed and let her scream' (Steve & Terry)),* and behaviour, stating children struggled to disclose information relating to past experiences with their birthparents *('she doesn't really tell me anything about her previous life', (Sarah)).* All carers reported extreme behaviours they found challenging: *'I was being controlled by this child' (Clara), 'he was really violent and horrible' (Laura).*

## 4. Impact on carer wellbeing and need for support themselves

The new caring position came at the expense of carer's basic needs, social relationships and mental health. It highlighted their need for support.

### 4.1 No time to rest, no time for basic needs

Carers explained their role meant less time for work or themselves with some retiring following the SGO. Most (4/5 families) had to cut back hours, find flexible employment, give up work altogether (*'I had to give up work, (Emily & Rebecca)),* or involve the children *(The kids get involved…so no, it hasn't impacted (Laura)).*

Carers lamented not having time to rest (‘*we don't have any time really to ourselves…I could really do with a rest’, (Steve & Terry)).*

### 4.2 Reduced access to social networks and intimate relationships (love and belonging)

Carers appeared resigned to not socialising, holidaying, or doing anything other than overseeing their charge. Taking on this role impacted all of the interviewees’ ability to socialise, whether it was as a couple *(‘what me and hubby miss, we used to like having a long weekend by the coast’, (Laura))* or with others *(‘you had to give your social life up’ (Emily & Rebecca))*. Since most carers were grandparents, some struggled to create relationships with other parents in school due to the age difference (‘*I could not connect with anyone … because it was such a vast age difference’, (Clara))*. Carers depicted limited and precarious support networks composed of family (often ageing parents), and a few close friends. Carers expressed either a sense of loss for levity *(‘It’s the day-to-day kind of socialising…that's what's missing’, (Clara)*. or a longing for someone to talk to *(‘I don't really have anybody’(Sarah))*.

### 4.3 Emotional burden and mental health needs (well-being and self-esteem)

Carers described poor mental health (4/5) *(‘depression’, (Clara))*, becoming tearful during the interview and alluding to moments of suicidal ideation (‘*I didn’t wanna carry on’, (Emily & Rebecca))*, with only one family ‘just’ coping *(‘it sometimes is never ending. But I think we're coping quite well’ (Steve & Terry))*.

Abuse from the child meant one only felt better after the child was returned to the care of the state: “*I seem to be getting back to my normal self again’ (Emily & Rebecca)).*

Mental health support (medication and talking therapy) had been offered occasionally. Carers were ambivalent about psychological input stating that it would be helpful to *'let off worries" (Laura)* but also: '*but it's too difficult for me', (Sarah)).* Community support was helpful to normalise experiences: '*it was also nice to be in a room with other people who were in the same situation', (Steve & Terry)).*

**Attach feedback and change ideas**

Overall, feedback for Attach was positive *('they're absolutely brilliant' (Sarah)).* Carers explained that input from the service had improved communications (*'how to explain the mummy thing' (Steve & Terry)),* and helped them make sense of the children's behaviour *('that six week course… enlightened us a bit as to different ways of looking at why they're reacting like they are' (Laura)).* Carers wished for earlier input *('I wish I'd been in touch with them 3 1/2 years ago', (Sarah)),* that the support would be ongoing *('as the children develop and change', (Steve&Terry))* and offered as 'protocol' *(Emily & Rebecca),* inclusive of check ins of the children. Some suggested direct one-to-one support beyond parenting: *'there is more to our boys than just the parenting sides', (Clara).*

Other change ideas included: guidance around legality of caring orders, a reading list, community support with professional oversight, help managing contacts, respite, and mental health support.

**Recommendations and Service Feedback**

Preliminary recommendations were developed in response to unmet needs emerging from the analysis, ideas listed by interviewees, and the existing literature. These were discussed with the service psychologist before being presented to the team along with research findings. The team considered service limitations, scope and

feasibility in their implementation. Their feedback was incorporated alongside service recommendations (additional recommendations for the commissioning body are included in Appendix N).

| Recommendations | Rationale | Feedback from discussion with the service |
|---|---|---|
| **Navigating services and help-seeking** | | |
| **Guidance in accessing services: contribute to a map to contact services including charities** | Attach work closely with the council and Adopt Thames Valley and could help to create a map of services by contributing information regarding access to mental health support for children and carers alike. This would be available in schools, GPs, and social care. It would include details of charities that can also provide support and any local community group. | Professionals noted that there were systemic issues underpinning access to services, notably lack of funding. They wondered how they may influence the wider system. Did the team need to be advocating for the needs of carers more and bringing up the idea of a hierarchy of needs?<br>Highlighting gaps in services and support that used to exist and the continued need for it. Schools as good places to put information – most accessible for carers. |
| **Developing legal/social/mental health pathways system (e.g., a social care advocate like a mental health advocate)** | ATTACH could advise on the development of protocols to access and integrate support from health, safeguarding, CAMHS, social care and attach. | There is a dedicate phone helpline provided by the local authority that could help to integrate support. Sadly, carers were not aware of it in our interviews. Attach will feedback to the helpdesk and the local authority about the lack of integration and how carers are failing to access the available support due to not knowing about it. Findings will be disseminated about the needs of carers and how these can be met by the council. |

**Table 3.** *Recommendations for the Attach service per superordinate theme*

| Recommendations | Rationale | Feedback from discussion with the service |
|---|---|---|
| **Negotiating new family structure and relationships** | | |
| **Developing materials with information around challenges of transition, new structure and attachment. For example: preplacement training, a dedicated website, a welcome pack, a support booklet for carers** | In our interviews, carers described a gap between their expectations and the realities of caring. Good quality preparation enables special guardians (SGs) to understand their role and responsibilities, and to prepare for the challenges to come. This, in turn has been shown to better integration of the children and reduced stress for carers when managing the children's complex needs. | The team reflected that there needs to be a better relationship with the helpdesk so they can connect carers to the service and not simply allocated to a waiting list. Currently, safeguarding is a main pathway to support from the service. Better access would enable for preventative work to take place replacing the current crisis model. Attach will seek to increase advertising services with the school. To go past any barriers to engagement, professionals believe that it would help for support to be brought up by designated teachers. |
| **Group about attachment and transition** | Information about naming and attachment is key and not well known. Attach's SGO group course should be offered as standard by carers and/or social care staff who could then pass on the knowledge. This would help carers have time to prepare for the transition and adjust their expectations, thus providing some normalising and reassurance ahead of difficulties. | Attachment, transition and talking about naming could all be incorporated in the existing group or a life story group. Attach will consider having another 6-week course on offer.<br>There should be a preparation group for SGOs as there is for adopters within the local authority. Knowledge needs to be shared between teams (e.g. training staff in the council to better support carers earlier). |
| **Reading list with books about naming the role or new family structures** | Book recommendations were mentioned by carers as helpful, in particular books for children who supported them in understanding the new family structure. These could be passed on to social care and schools for early dissemination in caring journey. | There is a list in place but Attach will tailor one for SGs and make it available across agencies. |
| **Changes to first contact and assessment, to be incorporated to the proforma.** | In order to effectively fulfil their role carers need to feel supported and look after their well-being, this starts with acknowledging their difficulties and empathising with the challenges they face. Their needs must be listened to before they are asked to move into action and learn new reparenting skills with the children. | Professionals will acknowledge with the carers that: caring for their charge is difficult and not as expected; the loss and sacrifices with which they are faced, the burden of caring and their unmet needs; before starting to explain that the solution is reparenting differently. Carers will be asked more directly about loss in assessment and their supportive relationships. Contact is not a separate question in the assessment currently, this will be incorporated moving forward – 'what are the arrangements, how are they experiencing it? Assessment letters will incorporate a clear paragraph about what to do if they have difficulties and signposting details. Furthermore, in assessment clarity will be a priority in terms of how the service can help, where to get additional support, but also given the carers permission to say this is a doctor's appointment when needing to take time off work. A few quick tips will also be given to increase engagement with the approach. |
| **Support with contact** | Psychologists are uniquely positioned to formulate conflict in relationships and its management. Therefore, ATTACH could help families make sense of tensions with birthparents and how to negotiate contacts and the difficult emotions that come with that. SGs get no help with contacts, not from social workers usually, despite a potentially much more stressful contact arrangement than foster carers. | Currently the service does not support with contact, although they offer social workers guidance about this if they ask for it.<br>Attach will consider incorporating into the group guidance on how to cope with SGO new family that provides reassurance/guidance and helps to normalise experience. It links with work the team is already doing on siblings and contact. The team may be able to harness this expertise. |
| **Life Story Work course for carers** | Life Story work could help carers and the child/ren alike adjust to the new structure and provide a platform for important conversations about it. | ATV life story work is already taking place but there is an issue around carers not knowing about this. They may not be on the adoption service circulation list. Attach needs to work on accessibility.<br>Offering a life story group specifically for kinship SGs.<br>Options like SGO buddy or SGO graduate group did not work due to poor attendance – this is a difficult to engage group. Better integration with schools could help improve access, as well as rethinking language around support available so that carers understand options better. |
| **Transition to independence** | Carers have lamented that support has come too late or at crisis point. If support is offer more consistently at the start of the SGO, services will want to plan for transition to independence to manage financial pressures on the service. | The team reflected the need to support carers with self-care and loss, possibly with a group that is just for them not about the children. (This would be part of the same group, not a third one – i.e., contact, loss, self-care)<br><br>Increased engagement with helpdesk could help link carers in with support. This needs to be better advertised to carers. |

| Recommendations | Rationale | Feedback from discussion with the service |
|---|---|---|
| **The challenge of caring in adversity** | | |
| **Routine screening of the whole family (e.g. questionnaires, check ins).**<br><br>**Consultation for SG support assessment** | One carer mentioned complex needs not being identified early enough leading to placement breakdown. An initial assessment would help identify difficulties at an earlier stage and provide an opportunity for early intervention before the placement becomes unstable. | Carers can call helpdesk 5 days a week, this needs to be better advertised and linked up with the service. The team was open to being put in touch with families for review when needed and appeared to prefer that to the idea of a drop in or the use of psychometrics outside of the service. |
| **Better integration with CAMHS** | Carers described finding it confusing to know where to access support for their child and being confused between CAMHS and Attach. | Helpdesk could provide guidance and support in choosing appropriate support. |
| **Follow up as children hit developmental different stages – a booklet on milestones with shared experiences** | The need for continuous support was highlighted by families.<br>It would be helpful for carers to be warned about expected changes and challenges through development, but also to know what signs to look for and how to get in touch with services if needed. The path back into support would ideally not have to involve starting a new when a family has already been with the service. | Unfortunately, services find it hard to have clients open on their caseload but they could be r-ereferred through helpdesk.<br>However, the service will make it clear that the service has an open-door policy to come back. Treatment endings will incorporate information about warning signs and how/when to refer oneself back if needed., |
| **Drop in consultations** | Carers described struggling to get help in crisis, having to go through safeguarding services to access support. Drop in consultations would offer a simple and fast way for them to do so. | The team said they would consider the idea of drop in consultations but needed to work out practicalities. |

| Recommendations | Rationale | Feedback from discussion with the service |
|---|---|---|
| **Impact on carer wellbeing and need for support themselves** | | |
| **A support worker or assistant psychologist to provide a point of contact and someone to process experiences out loud with and from whom obtain reassurance if needed.** | Carers explained how much they appreciated contact with Attach, and really valued the opportunity to share their difficulties and be reassured they were taking the right course of action. | Attach is not able to provide this sort of support.<br>This is more the role of Adopt Thames Valley team and the service Helpdesk which needs to be better advertised. Referral to Attach as necessary from Helpdesk.<br>More comprehensive information about what Attach offers and how it can help them with parenting could help carers better understand the support available, that it means learning to parent differently of their charge. |
| **Facilitate or signpost to community support group for validation, reassurance, and upskilling/tips (consultation)** | Carers explained how they had valued the opportunities to hear the experiences of their peers to normalise their own but also share insights and ideas. Currently, there are support groups run by charities that carers may not be aware of and signposting them may be sufficient. | Community support groups have lacked uptake in the past, these need to be better integrated with schools, more flexible and better advertised to encourage uptake. |
| **Facilitating a Well-being for Carers' workshop** | Carers struggled to prioritise their well-being and a space dedicated to this purpose may support them to find sometime to look after themselves and increase their resilience. | Professionals identified that a self-care element in the groups would be helpful as described above. This would not be an additional group. Professionals thought they may want to explain how looking after their well-being would help carers with their role. |
| **Pre SGO preparation for carers** | Could recommendations or psychoeducation be developed with the council? Is there the need for another group? Or when / how groups are offered? As standard directly by council? | This needs to be addressed and the service will link up with the council to review what is in place and its appropriateness/delivery. |
| **Information and signposting to services for individual one to one mental health support or other support services when needed.** | Carers managed children's complex needs and prioritised their well-being often at the expense of their own whilst trying to locate and access support for the child. Better integration of services is key to help carers access appropriate support, standard mental health primary and secondary care may not be appropriate for some of the difficulties these families are experiencing. Attach is uniquely positioned to cooperate with mental health services in the region. | Carers should have details of the helpdesk and a list of agencies. The service will enquire about this and make recommendations as needed.<br>The service will actively check that carers are aware of helpdesk during first contact (e.g., do you know what helpdesk is, have you called it, do you know what it is for?) and include a list of agencies in correspondence which will be repeated over time. |

| Recommendations | Rationale | Implementation |
|---|---|---|
| **Miscellaneous** | | |
| **Workforce Development Plan Core areas include – attachment, trauma, contact, identifying therapeutic need, equalities and diversity, and life story work. Specialist training included DDP, Therapeutic Life Story Work, Systemic Family Therapy, and Adult Attachment Across the Life Span.** | Supporting SGOs requires specific knowledge of working with families who manage physical, social, emotional and relationship challenges. Increased skills training across local authority services workforce could dramatically and quickly improve quality of contact. Attach is well placed to offer this training to staff. | *"I note the real need for liaison with other services and engagement with the organising processes /'protocols' of SGOs and see this as a big job, but clearly something important. Preparing SGs for what will happen seems to have been neglected – as we have been hearing in the news recently – and I fear this is a big one to tackle."*<br>This is a longer-term outcome as the team needs to identify which professionals would be helpful to train. |
| **Data collection, monitoring and service development.** | To ensure the effectiveness and acceptability of the recommendations, it would be helpful to systematically pilot and evaluate them. Consulting families and gathering feedback for service development plans and delivery. | The service welcomed the idea of monitoring effectiveness and identifying barriers to troubleshoot implementation of new strategies.<br>Service user feedback will be sought regarding the usefulness and format of summary treatment letters to check whether this is a good use of time for clinicians and families are able to make the most of these to support recovery. |

### Dissemination

The results were summarised in writing and disseminated within Adopt Thames Valley, local council adoption support services and other relevant adoption and fostering organisations.

## Discussion

This service improvement project interviewed special guardian kinship carers offered support by the Attach team with a view to identifying their unmet needs and providing recommendations to improve the service.

Needs were identified in different layers of the bio-ecological model following the superordinate themes and mapped onto the existing evidence base.

**Services**

Carers' needs for support were not met due to issues of accessibility, timing, and provision from services as hypothesised in the special guardianship review (2015) and other investigations (Wade, 2014) .

Carers found themselves relying on informal proximal sources of support to fill the gaps left by the lack of services (Ashley & Braun, 2019) whilst trying to locate and access support for the child to meet needs beyond their scope. With more adequate provision and information, carers could obtain support needed to meet caring demands whilst safeguarding their well-being (Dozier et al., 2002). This would relieve some of the negative impacts on them from not being able to meet the needs of the children when they have no external resource to provide the required support.

**Family**

As echoed in the literature, carers reported difficulties managing contacts and the family restructure: in how it changed their relationship with the birthparents (Kiraly & Humphreys, 2016; McGrath & Ashley, 2021), in choosing between supporting the latter or the child/ren, in risks posed to the child/ren, and in explaining the SGO to the children (Hall, 2019).

Lack of support around contact and managing the transition meant the family system was struggling (Selwyn, 2014; Wade, 2014). Carers felt stretched from taking on

responsibilities and managing demands beyond their expertise and for which they were not prepared.

As evidenced in similar research (Hall, 2019), carers faced risk to themselves, through family related abuse from child and birthparent, and from secondary trauma, and lacked support from the system.

**Child**

Carers reported feeling ill prepared to meet the challenges of caring for traumatised children alone (McGrath, *in preparation*), and abandoned (McGrath, *in preparation*) due to withdrawal of services post SGO (Yong, 2018). Lack of support around the challenges of caring in adversity meant the carers felt overwhelmed and this added to the pressure felt to look after the child/ren and to deprioritise their own well-being (Ashley & Braun, 2019).

These findings matched research emphasising the need for preparation (Kiraly & Humphreys, 2016) and support from the system (Ashley & Braun, 2019), responding to unexpected behavioural challenges and attachment needs (Special guardianship review, 2015; Wade, 2014). These proximal processes are necessary for caregivers to feel successful in their role and provide the child with emotional responses that make them feel safe (Golding, 2020).

**Carer**

Findings showed the impact on carers of insufficient practical help was lacking time to rest (Hall, 2019). Carers had to give up employment to balance the time demands of safely managing their new responsibilities (Wade, 2014) and it strained their relationships leaving

them wanting for emotional and community support (Plus, 2017) and isolated (Stobbs & Prowle, 2017).

The carers' attempts to find the time and resources to meet the needs of the child without sufficient support resulted in the loss of their own support layers, which may have weakened their resilience and impacted their mental health. This may have jeopardised their effectiveness as carers: to be a supportive layer that fosters the child/ren's well-being and mental health (Dozier, Higley, Albus, & Nutter, 2002); and to create safety (Golding, 2020) and placement stability (Houshyar, Gold, & DeVries, 2013; Maslow, 1954). Support from services is needed to help carers regain these proximal processes, to increase functioning potential and create sustainable family systems long term (Bronfenbrenner & Ceci, 1994).

## Limitations

Using Yardley's qualitative research evaluative criteria, we considered the strength and weaknesses of the qualitative work, including: sensitivity to context, commitment and rigor; transparency and coherence; and impact and importance (Yardley, 2000, 2008).

The sample was small due to difficulties recruiting a hard to engage population further overwhelmed by caring demands exacerbated by Covid-19 pandemic, and favouring online solutions less due to age. Participants were self-selected implying the possible over-recruitment of those with strong views, biasing an already small sample. It was also homogenous in gender, ethnicity and sexual orientation. Whilst generalisability is not a principle of thematic analysis, the findings provide valuable insight into the experiences of SGO carers within this service and are consistent across participants, the literature and clinicians' experiences which increases confidence in our data.

Length of time since the SGO was unknown, meaning the sample may have been heterogenous and participants struggled with different stages of caring, whether initial transition or eventual burnout. Considering the importance carers attributed to the timing of support, future research should collect data to contextualise views within the caring journey.

No service users were available within the time frame necessary to contribute to the question development and data analysis to address bias in selecting questions. To show sensitivity to participants' perspective, though initial questions emerged from a pre-conceived theoretical framework and clinician views they remained open ended questions. Participants were encouraged to share negative views through a non-judgmental stance from the researcher and highlighting of confidentiality. Meanings produced by the participants were carefully considered by the researcher.

The researcher demonstrated their commitment and rigor through immersing themselves fully in the data, involving supervisors in the development of themes, and clinicians in checking that the themes fit with their experience.

Every effort was made to show clearly how the interpretation was derived from the data in the methodology, through illustrative quotes in the results, and a comprehensive paper trail in the appendices.

**Clinical implication and future research**

The consistency of the findings with the literature as detailed above illustrate the need to implement changes to service provision such as care respite, support managing family contacts and training courses (Ashley & Braun, 2019).

Actionable recommendations outlined in Table 3 will be put into practice and reviewed through an audit of acceptability and effectiveness to complete a cycle of quality of improvement. Others will require further consideration and approval from commissioners. Further research should aim to continue to pilot and evaluate improvement ideas suggested in Table 3.

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# Theoretically Driven Research Project (TDRP)

# Sensitivity to betrayal and new intimate relationship building in survivors of intimate partner violence

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**Abstract**

**Objectives** Betrayal sensitivity is conceptualised as how sensitive someone is to the possible experience of further betrayal and the subsequent negative impact of such betrayals. There is evidence which suggests that prior experience of IPV can lead to high levels of sensitivity to betrayal, shame, and self-criticism and therefore may interfere with initiation, development and maintenance of future intimate relationships. We aimed to examine levels of betrayal, shame, and self-criticism in women survivors of IPV, and to evaluate whether survivors who are satisfied with their intimate relationships – as well as women without a history of IPV- are less sensitive to being betrayed compared to those dissatisfied with their relationships or single.

**Design** A cross-sectional, between-groups design was used, comparing women survivors of IPV divided into those satisfied with current intimate relationships, those dissatisfied and IPV survivors not in such a relationship. Women without a history of IPV were included as a benchmark group.

**Method** Four groups: IPV single (N= 34), IPV dissatisfied (N= 25), IPV satisfied (N=32), and those who had not experienced IPV (N= 42) were compared for betrayal sensitivity, followed by a secondary comparison of shame and self-criticism. Questionnaires were completed online by participants recruited through social media and screened for IPV and relationship status.

**Results** All IPV groups had significantly higher scores for betrayal sensitivity than the non-clinical group, with IPV Satisfied having significantly lower scores than other IPV groups in two subscales: betrayal causing life change and lack of trust due to betrayal.

**Conclusions** Betrayal sensitivity is present amongst all survivors of IPV with evidence of a specific link between survivors' relationship satisfaction/status and their lack of trust and being permanently changed beliefs. It may be that those appraisals make it

more challenging to build and maintain satisfactory relationships, or that positive relationships help survivors change their appraisals about betrayal leading to lack of trust and life altering changes.

**Key words:** 'Intimate Partner Violence', 'Betrayal', 'Relationships' 'Self-criticism', 'Shame'

# Introduction

## Intimate partner violence

Intimate partner violence (IPV) is a worldwide phenomenon, with a prevalence of 30% of women around the world having experienced IPV, and about 25% in Europe and 23% in rich countries (World Health Organisation, 2013). It is defined by the World Health Organisation (WHO) as a "behaviour within an intimate relationship that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse (e.g., verbal abuse) and controlling, coercive, repeated behaviours" (WHO, 2010). A wide and inclusive definition of IPV was chosen which includes verbal abuse, because it is known that non-physical acts of abuse such as coercive control also have significant psychological consequences for survivors. This abuse maybe perpetrated by men and by women toward romantic partners of the same or opposite sex.

IPV is listed within DSM-5 under 'Other conditions that may be a focus of clinical attention' (American Psychiatric Association, 2013) as one of the relational problems that may characterize intimate adult partner relationships. As such, IPV is not a diagnosis or a intra-psychic concept, which can make it difficult to find studies and theoretical models that investigate the clinical relevance of such experiences and has led to its conceptualisation more broadly under the umbrella of 'trauma' or 'interpersonal trauma'. This in turn means that IPV research, like the remainder of the trauma literature, has focused mainly on the intrapsychic negative sequelae of the experience by tracking associations with depression, posttraumatic stress disorder, and anxiety (Samios, Raatjes, Ash, Lade, & Langdon, 2020). This could distract from a more inclusive understanding of a variety of psychological and relational responses (Elderton, Berry, & Chan, 2015). An important consideration for many

of those who have experienced IPV is the development (or not) of future intimate relationships.

Although there is little research on the experiences of IPV and new relationship building, it has consistently been suggested that domestic violence survivors experience significant relationship consequences, such as reduced likelihood of marrying and cohabitating (Burton, Cherlin, Winn, Estacion, & Holder-Taylor, 2009; Cherlin, Hurt, Burton, & Purvin, 2004; Macmillan, 2001; Manning, Trella, Lyons, & Du Toit, 2010; Vandervoort & Rokach, 2004). Research into the details of interpersonal difficulties following IPV, and into rebuilding relational aspects of their lives in the medium to long term has largely focused on identifying risk factors which may predict and prevent revictimisation. This focus has in large part been determined by the coordinated global effort from the WHO and other charities to reduce IPV and more specifically violence against women, but one may question the utility of an 'aetiological' approach for psychologists providing individual one-to-one therapy to survivors rebuilding their lives. There are few longitudinal studies with survivors of domestic violence which means that little is known about how they establish new intimate relationships. However, a recent longitudinal study (Kelly, Sharp-Jeffs, & Klein, 2014) has found that most survivors in their study chose to remain single to stay safe rather than risk re-entering an abusive relationship. It would appear that fears of revictimization may not only be the main concern for the world health institutions but also for survivors, and the mechanisms by which it impacts survivors' ability to find and trust new partners safely (Kelly et al., 2014) are poorly understood.

**Relationship avoidance as self-protection**

The experience of IPV affects survivors' trust in future relationships as they may anticipate further betrayal experiences from intimate partners. Qualitative research suggests

that survivors of IPV are indeed fearful of or expect violence when entering new relationships (Kelly et al., 2014; St. Vil, Carter, & Johnson, 2018). Similarly, in other betrayal traumas, survivors find it difficult to know whom and when to trust (Altmaier, 2016) and may be on high alert for a possible new violations of trust. In order to protect themselves from revictimization, IPV survivors have been shown to use a number of coping mechanisms that interfere with intimacy (Kelly et al., 2014; St. Vil et al., 2018). Experience of and sensitivity to betrayal may thus be a barrier to initiating, building and maintaining relationships. If this is so, it could be predicted that survivors who are highly sensitive to betrayal will be less likely to be in a fulfilling intimate partnership and *vice versa*.

**Identifying interpersonal trauma as betrayal trauma**

The interpersonal nature of the trauma, where the stressor comes from the actions of a trusted person, has been highlighted as a factor that may account for severity and chronicity of PTSD (American Psychiatric Association & Association, 1994). Betrayal has been shown as a factor which could play a significant role in predicting psychopathology, including but not confined to PTSD (Freyd & Birrell, 2013). Betrayal may also explain aspects of etiology (Kelley, Weathers, Mason, & Pruneau, 2012) and shed light on the mental health effects of exposure to IPV. Though physical wounds may heal, the emotional consequences of interpersonal trauma can persist and affect future relationships (Freyd, Klest, & Allard, 2005; Platt, Barton, & Freyd, 2009). In her theory of Betrayal Trauma, Freyd suggests that it is the proximity of the relationship to the abuser which is crucial (Platt & Freyd, 2015). Thus, the conceptualisation of the way in which betrayal trauma has lasting effects may account for the mental health effects of interpersonal trauma and IPV.

The concept of betrayal has been widely studied, including in institutional betrayal (Freyd, C. Brewin, 2003; Freyd, 1998; Shay, 2010) and a subtype of obsessive compulsive

disorder (OCD), mental contamination (Pagdin, Salkovskis, Nathwani, Wilkinson-Tough, & Warnock-Parkes, 2021; Rachman, 2010). Betrayal sensitivity is conceptualised here as how sensitive someone is to the possible experience of further betrayal and the negative impact of such betrayals including but not confined to shame and self-criticism.

**Shame and self-criticism in survivors of IPV**

Shame and self-criticism are common sequelae to interpersonal traumas, particularly betrayal traumas such as intimate partner violence and childhood abuse (Karakurt, Smith, & Whiting, 2014; Edward S Kubany et al., 1996). Betrayal trauma is associated with shame (Platt & Freyd, 2015), which in IPV is known to lead to beliefs about being to blame for 'being a bad partner' or 'not having left sooner' (Edward S Kubany & Ralston, 2008). Self-criticism is also documented in survivors of IPV and has led to the development of interventions to promote self-compassion in survivors, which has been shown to decrease following interpersonal traumas (Bistricky et al., 2017). Shame and self-criticism predict greater prevalence of mental health difficulties including PTSD, depression and anxiety (Beck et al., 2015; O'Neill & Kerig, 2000), and may themselves negatively impact survivors' ability to form new relationships, linked to increased avoidance (Joseph, Williams, & Yule, 1997). We therefore intend to identify the extent of shame and self-criticism (and the relationship to betrayal sensitivity and relationship status and satisfaction).

There is thus evidence which suggests that prior experience of IPV can lead to high levels of sensitivity to betrayal, shame, and self-criticism and therefore may interfere with initiation, development, and maintenance of future intimate relationships. Understanding these interrelationships better could identify possible interventions and effective ways of supporting and empowering survivors to manage and (if they wish) to foster fulfilling partnerships. The current study aimed to examine levels of betrayal, shame, and self-

criticism in three groups of women survivors of IPV those ‘in a relationship and satisfied’ group (described as ‘IPV satisfied') with two other groups either ‘single’ (IPV single) or ‘not satisfied with their relationship’ (described as ‘IPV dissatisfied'), and an additional benchmark group of women who have not experienced IPV (non-clinical group).

In this study we hypothesise that there will be a relationship between continuing sensitivity to betrayal and the development of new intimate relationships; that sensitivity to betrayal will be higher both in those with past experience of IPV who are currently single and in those dissatisfied in their current relationship relative to the other two groups. The secondary hypothesis is that self-criticism and shame will also be higher in IPV single and IPV dissatisfied group relative to the other two groups.

## Method

### Design

The study employed a between-groups design using quantitative methodology to investigate sensitivity to betrayal, self-criticism, and shame across four groups with or without previous experience of Intimate Partner Violence (IPV); IPV groups were defined in terms of their current relationship status, that is: IPV satisfied, IPV single, IPV dissatisfied, non-clinical group.

### Recruitment

All participants were recruited online, focusing on online survivor and relationship groups through study advertisements in the form of digital flyers stating the anonymous and online nature of the survey the aims of the study, (see examples in Appendix O), with links to the survey and the department’s online research page. This was posted to Twitter,

Facebook, and Instagram. Domestic violence organisations (i.e., Berkshire Women's Aid, and The Violence, Abuse and Mental Health Network VAMHN) and radio hosts (i.e., @litfriction) promoted the study through their online platforms. The researchers also posted the flyers to their own professional accounts and across several online community groups. A snowballing approach was also used, whereby participants were encouraged to share the study with others known to them.

**Selection Criteria and Participants**

Individuals were eligible to take part if they were 18 or over, could read and write English, and currently were or identified as a woman and were no longer in the IPV relationship.

Participants were not included if they self-reported symptoms of psychosis and/or bipolar disorder, indicated that they were currently at risk from their new partner, or the abusive relationship with their former partner had ended less than 1 year ago.

Participants were allocated to the non-clinical group if they answered "NO" to question "Have you ever been in an intimate partner violent relationship?". Participants who answered "Yes" to that question and "NO" to the question : "Are you in a relationship?" were allocated to IPV single group (n=34). The remainder of the participants who answered yes to both questions were divided in two groups. It was decided a-priori that IPV Satisfied and IPV Dissatisfied would be allocated to two groups based on an enhanced median split of their DAS-7 scores. The median for this group was identified as 25, and those scoring more than 2 standard errors above and below were removed from the groups IPV used here: IPV Satisfied n=34 and IPV Dissatisfied n=25. Seven participants were not included for the between group analyses but are included in the regression analyses.

**Measures**

Sociodemographic characteristics were also collected, including participants' age, gender, ethnicity, employment status, and level of education. Additional questions focused on previous mental health difficulties, support and trauma history can be found in the Appendix Q. Validated study measures are detailed in Table 1.

**Table 1.** Overview of validated measures used in the study

| Domain | Measure |
|---|---|
| The Dyadic Adjustment Scale (DAS-7), or Abbreviated Dyadic Adjustment Scale (ADAS; Hunsley, Best, Lefebvre, & Vito, 2001) | The DAS-7 is a 7-item self-report measure designed to assess the relationship quality of couples. This shortened version of the original from the original DAS-32 (Spanier, 1976) includes items aimed at assessing relationship satisfaction and the degree to which the couple agrees on matters of importance to the relationship and is sensitive to change (Halford et al., 2012; Ireland, Sanders, & Markie-Dodds, 2003; Zubrick et al., 2005). Scores below 21 indicate a relationship in distress (Hunsley et al., 2001).<br>The DAS-7 has established validity and good internal consistency with Cronbach's Alpha ranging from 0.76 (Sharpley & Rogers, 1984) to 0.84 in female participants (Hunsley, Pinsent, Lefebvre, James-Tanner, & Vito, 1995), but no evidence relating to the test-retest reliability. Current study α=712 |
| The Perception of Betrayal Scale (POBS) (Pagdin, Warnock-Parkes, | A 27-item questionnaire assesses the impact of betrayal on different aspects such as self-perception, interpersonal relationships, and behaviour. This measure was found to have high reliability (internal consistency) at Cronbach's alpha = .95. |

| | |
|---|---|
| Nathwani, Salkovskis, 2021) | Preoccupation with past betrayal events subscale (α = .94), betrayal causing life change subscale (α = .89), lack of trust due to betrayal subscale (α = .88) and the betrayal leading to traumatic responses subscale (α = .81) all showed good reliability.<br>Cronbach's alpha for the current study was α= .978. Preoccupation with past betrayal events subscale α= .963, betrayal causing life change subscale α= .961, lack of trust due to betrayal subscale α= .946, betrayal leading to traumatic responses subscale α= .821. |
| Forms of Self-Criticism/Attacking and Self-Reassuring Scale (FSCRS; Gilbert, Clarke, Hempel, Miles, & Irons, 2004) | A 22-item Likert scale developed to measure self-criticism and the ability to self-reassure. It is made up of three components including two forms of self-criticalness: inadequate self and hated self; and one form of self-reassurance. It has been found to have good validity and reliability (Baião, Gilbert, McEwan, & Carvalho, 2015). It has showed good internal consistency with α= 0.90 for inadequate self and 0.86 for hated self and reassured self respectively.<br>In the current study all subscales showed good internal consistency: inadequate self α= .919, hated self α=.856, and reassure self α=.894 |
| Other as Shamer Scale (OAS) (Goss, Gilbert, & Allan, 1994) | The OAS is a valid and reliable measure of external shame (i.e., global judgements of how people think others view them). It is an 18 item, self-report, 5 point Likert scale, with Cronbach's alpha: 0.92 (Goss et al., 1994). Current study α= .0.958 |
| Experiences of Intimate Partner Violence | A 9-item questionnaire created for the purpose of this study to identify/record the different types of violence and abuse experienced by survivors in historic intimate partnerships. This includes physical (e.g., *'I sustained physical injuries following an argument or fight with my former partner'*, psychological (e.g., '*My former partner used threats and intimidation*') and sexual aggression, as well as digital abuse (e.g., '*My* |

*former partner posted unwanted photos and videos of a sexual nature on the internet*').

## Procedure

Data were collected through an anonymous online Qualtrics survey software. Participants accessed the survey via weblinks included on study advertisements and were presented with a Participant Information Sheet (PIS) detailing risks and benefits of taking part in the study. Upon confirming consent form and inclusion criteria (Appendix P) participants progressed to demographic questions. The following questions about IPV experience and relationship helped to pre-allocate groups. Exclusion criteria questions (e.g. risk from current partner) came up to ensure participants met the criteria and avoid the collection of irrelevant data. All participants in a relationship were asked to complete a relationship measure (DAS-7 - Appendix R), this measure's total score helped to determine allocation to IPV satisfied or dissatisfied. Single women were not asked to answer questions about relationship satisfaction. On the last page, a debrief message was provided including a grounding exercise, contact details for accessing support for mental health support and domestic violence. Two women with lived experience of intimate partner violence were consulted regarding the design, procedure, materials and impact of the study to acknowledge the value of service users contributions to research development (National Institute for Health Research, 2018).

Data collection took place from January-May 2022 with ethical approval from the University of Oxford Central University Research Ethics Committee (R78380/RE001; Appendix S).

## Power calculation

Power analysis was conducted drawing from a study (Howkins, Millar, & Salkovskis, 2020) investigating sensitivity to betrayal and mental contamination using a similar methodology and analysis to the one proposed by this study. G*Power software indicated that for an ANOVA with total betrayal sensitivity as the primary dependent variable and an estimated effect size of cohen f=0.3; alpha = 0.05 and power of 0.8 the minimum required sample size is estimated to be a total of 128 participants. Consequently, this study aimed to recruit at least 128 participants (32 per group) from the community. A total of 140 participants were eventually recruited.

**Data analytic strategy**

Groups were compared based on Chi Square tests. For the purpose of statistical analysis, categories with smaller cell sizes were concatenated for age (collapsed into <36 and 36>), ethnicity (collapsed into 'White' and 'Non-white'), employment status ('In work or study' or 'Not working'), and highest level of education (Academic Higher Qualification and Non-academic).

Continuous data for the dependent variables were found to be normally distributed for the dependent variables based on Kolmongorov-Smirnov tests. In mixed-model ANOVAs, where the Mauchley test of Sphericity was significant, the Greenhouse-Geisser correction was applied and is indicated in the text below. Where significant interactions were noted in mixed model analyses, these were followed up by simple main effects and multiple comparisons using Tukey LSD except where Levene's test for equality of variance was significant, in which case the Dunnet's T3 non-parametric comparisons were used.

To test the first hypothesis, that betrayal sensitivity will be higher in the IPV Single and Dissatisfied group, conducted a mixed model analysis of variance (ANOVA), with

betrayal sensitivity (POBS) subscale as the within-subjects variable and group as grouping variable.

To test the secondary hypothesis that self-criticism and shame will be higher in the IPV single and IPV dissatisfied groups relative to the IPV satisfied group, we first conducted a mixed model ANOVA comparing self-criticism subscales across the four groups, and shame using a separate one-way ANOVA between groups.

As an additional exploratory analysis, we conducted a hierarchical multiple regression with these three measures as IV and the participants DAS-7 score as DV.

## Results

Demographic characteristics of each group are summarised in Table 2 in Appendix S. The total number of participants enrolling was 140; 34 in the IPV single group, 25 in IPV dissatisfied group, 32 in IPV satisfied and 42 in the non-clinical group.

Chi-square analyses indicated no significant difference between the four groups in ethnicity (p = .937) and employment status (p =. 330). Significant associations were however found between groups in age ($\chi^2$ (1) = 20.703, p<.001) and education status ($\chi^2$ (1) = 17.129, *p*<.001). Using partitioned Chi-square analyses, it was found that IPV Dissatisfied and Single were significantly more likely than IPV Satisfied to be 36 or above ($\chi^2$ (1) = 9.687, p=.002, $\chi^2$ (1) = 4.331, p=.037 respectively). No other significant differences were found for age and education.

Significant associations were found between groups in self-reported depression ($\chi^2$ (1) = 23.597, *p*<.001), anxiety ($\chi^2$ (1) = 8.559, *p*<.036 and PTSD ($\chi^2$ (1) =25.551, *p*<.001). Using partitioned Chi-square analyses, it was found that the IPV Single group were

significantly less likely than IPV Dissatisfied to have experienced depression ($\chi^2$ (1) = 5.001, p=.025). No other significant differences were found for depression, anxiety and PTSD on partitioned analyses.

Abusive experiences were each recorded with a score of 1 and added together to produce a total out of 9. A one-way ANOVA on IPV experiences between IPV groups found no significant effect of group $F_{(2,90)}$ =.610 , $p$ <.545.

Table 3. *IPV total mean scores by group*

| | IPV Single Group *n*= 34 Mean (SD) | IPV Dissatisfied Group *n*= 25 Mean (SD) | IPV Satisfied Group *n*=32 Mean (SD) |
|---|---|---|---|
| IPV experiences total | 5.03 (2.07) | 5.36 (2.06) | 4.75 (2.08) |

**Primary outcome variables**

Table 4. *POBS subscales mean scores by group*

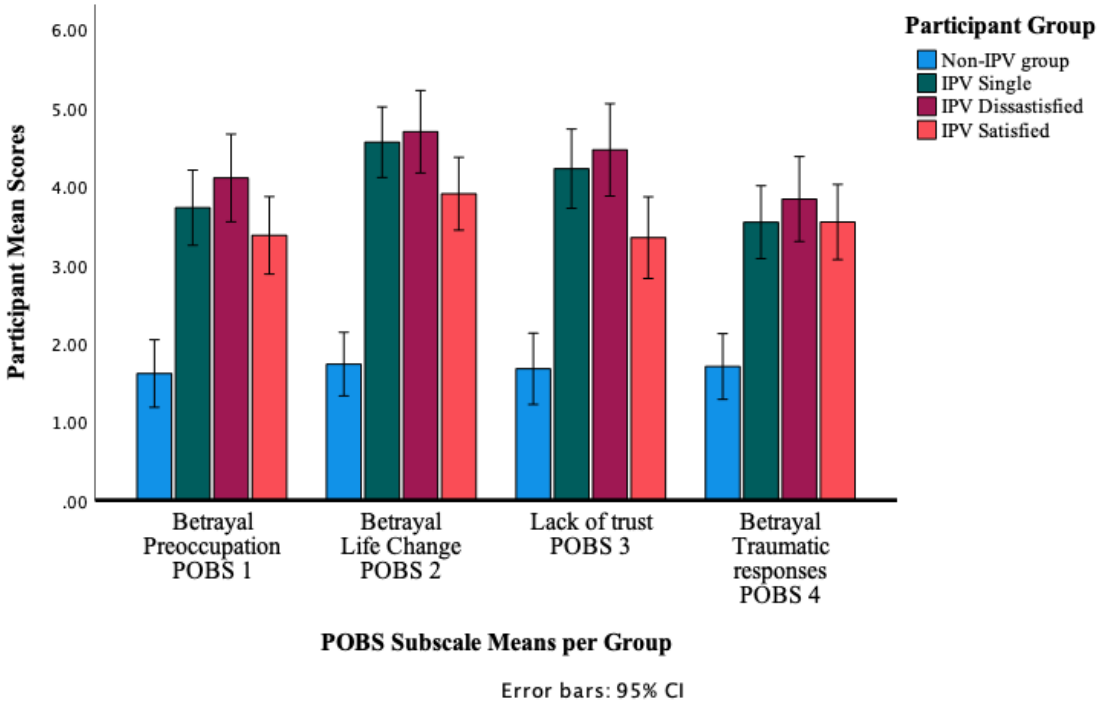
| | IPV Single Group *n*= 34 Mean (SD) | IPV Dissatisfied Group *n*= 25 Mean (SD) | IPV Satisfied Group *n*=32 Mean (SD) | Non-clinical Group *n*= 42 Mean (SD) |
|---|---|---|---|---|
| Preoccupation with betrayal events | 37.29 (*14.13*) [a] | 41.08 (*11.05*) [a] | 33.78 (*13.16*) [a] | 16.19 (*16.18*) [b] |
| Betrayal causing life change | 31.94 (*7.55*) [a,c] | 32.88 (*5.85*) [a] | 22.34 (*8.10*) [c] | 12.17 (*12.49*) [b] |

| | | | | |
|---|---|---|---|---|
| Lack of trust due to betrayal | 25.35 *(7.79)* [a,c] | 26.80 *(6.37)* [a] | 20.09 *(10.29)* [c] | 10.07*(9.87)* [b] |
| Betrayal leading to traumatic responses | 14.18 *(5.29)* [a] | *15.36 (4.79)* [a] | *14.19 (4.65)* [a] | 6.83 *(6.47)* [b] |

*Means which share subscripts are not sign diff (p>0.05)

A mixed-model ANOVA on betrayal sensitivity with subscales as the within subject variable and IPV group as grouping variable found a significant main effect of subscale type ($F_{(2.310,297.992)}$ = 12.268, *Greenhouse-Geisser p <.001)*. The main effect of group was also significant $F_{(3,129)}$=35.297, p<0.001. These effects were modified by a significant group by subscale interaction, ($F_{(6.930,297.992)}$ = 2.653, *Greenhouse-Geisser p <.001*); this is illustrated in Figure 1.

**Figure 1. Participant Mean Scores per Subscale per Group**



As the interaction was significant, simple main effects analyses for the POBS subscales were conducted by group. There was a significant main effect of group for all for subscales: Preoccupation with betrayal ($F_{(3,132)}$ = 22.341, $p$<.001) , Betrayal causing life change ($F_{(3,132)}$ = 39.689, $p$<.001), Lack of trust ($F_{(3,132)}$ = 26.172, $p$<.001), Betrayal leading to traumatic responses ($F_{(3,132)}$ = 19,107, $p$<.001).

Post-hoc multiple comparisons (LSD) show that the IPV groups were significantly higher across all the subscales of the sensitivity to betrayal measures relative to controls. Post-hoc multiple comparisons (Dunnett T3) also showed that the IPV satisfied group had significantly lower mean scores than IPV dissatisfied on 2 subscales (Betrayal Life Change $p$<.024, Lack of trust $p$<.023), but not on the subscales Preoccupation with betrayal events and Betrayal leading to traumatic responses. There were no other significant different between the groups across the other POBS subscales.

**Secondary outcome variables**

A mixed-model ANOVA was used to conduct an analysis on FSCRS (self-criticism) with the subscale (Inadequate self, Reassure self, Hated self) as within-subject variables and IPV group as grouping variable.

The ANOVA indicated a significant main effect of subscale $F_{(1.226,158.108)}$ = 121.646, *Greenhouse-Geisser p* <.001. The main effect of group was not significant, F(3,129) = 1.34, p = .265.

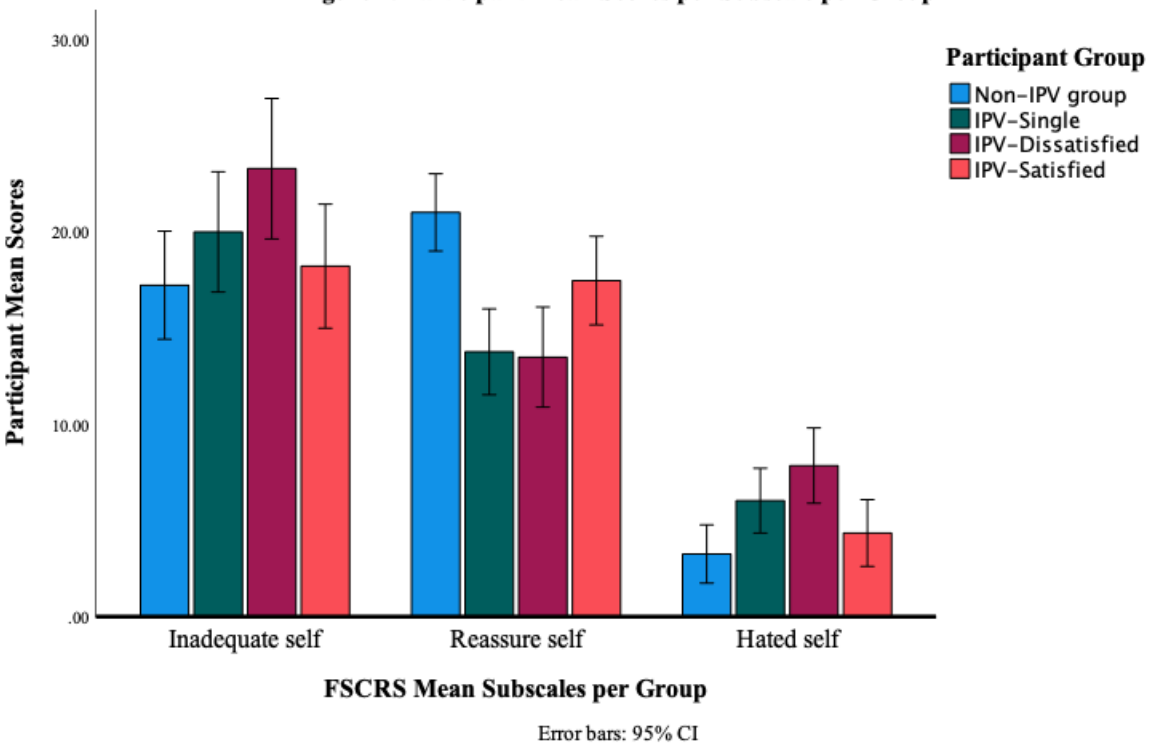
The main effect of subscale was modified by a significant group by subscale type interaction, ($F_{(3.677, 158.108)}$ =6.224, *Greenhouse-Geisser p* <.001); this is illustrated in Figure 2.

Table 5. *FSCRS subscales mean scores by group*

| | IPV Single Group *n*= 34 Mean (SD) | IPV Dissatisfied Group *n*= 25 Mean (SD) | IPV Satisfied Group *n*=32 Mean (SD) | Non-clinical Group *n*= 42 Mean (SD) |
|---|---|---|---|---|
| FSCRS Inadequate self | 20.03 (9.77) [a,b,c] | 23.32 *(9.31)* [a] | 18.25 *(8.38)* [b,d] | 17.26 (9.31) [b,c,d] |
| FSCRS Reassure self | 13.79 *(6.05)* [a] | 13.52 *(6.80)* [a] | 17.50 *(6.98)* | 21.04 *(6.55)* |
| FSCRS Hated self | 6.06 *(5.36)* [a,b] | 7.88 *(5.63)* [a] | 4.37 (4.57) [b,c] | 3.28*(4.45)* [c] |

*Means which share subscripts are not sign diff (p>0.05)

**Figure 2. Participant Mean Scores per Subscale per Group**



Simple main effects analyses for the FSCRS subscales were conducted to decompose it; two subscales indicated a main effect of group. Reassure self ($F_{(3,132)}$ = 10.370, $p$<.001) and Hated self ($F_{(3,132)}$ = 5.147, $p$<.001) but not Inadequate Self (p=.064).

Post-hoc multiple comparisons (LSD) showed that IPV Dissatisfied groups were significantly higher across the Inadequate Self than IPV Satisfied (p<.05) and controls (p<.05).

The IPV Dissatisfied (p<.001), and Single (p<.001) groups were significantly lower across the subscale Reassure self than controls (p<.001) and than IPV satisfied (p<.05). IPV Satisfied was also significantly lower than controls (p<.05).

The IPV Dissatisfied (p<.001), and Single (p<.001) group were significantly higher than controls (Hated self $p$<.05) and IPV Dissatisfied was significantly higher than Satisfied (Hated self $p$<.05). There were no other significant differences.

Shame

A one-way ANOVA was used to conduct an analysis on external shame between IPV groups. There was a significant effect of group $F_{(3,132)}$ =8.880 , $p$ <.001.

Table 6. *OAS mean scores by group*

| | IPV Single Group *n*= 34 Mean (SD) | IPV Dissatisfied Group *n*= 25 Mean (SD) | IPV Satisfied Group *n*=32 Mean (SD) | Non-clinical Group *n*= 42 Mean (SD) |
|---|---|---|---|---|
| Other as Shamer Scale | 34.68 (15.36)[a,b] | 34.76 *(12.43)* [a,c] | 32.03 *(16.48)* [b,c] | 20.16 (12.66*)* |

Post-hoc comparisons using LSD test showed OAS total was significantly lower in all IPV groups relative to the non-clinical groups, ($p$<0.05) which did not differ from each other.

Regression

A multiple linear hierarchical regression analysis for the full sample with relationship satisfaction as the DV was run, entering shame and self-criticism in the first ($F_{(2,62)}$ = 12.593, $p$<.001) $R^2$ = 0.266 . Sensitivity to betrayal was entered in the second step, giving ($F_{(3,61)}$ = 13.454, $p$<.001) $R^2$ = 0.369. indicating that sensitivity to betrayal scale accounted for an additional 10.9% of the variance.

Table 7. *Multiple regression results for FSCRS & FSCRS predicting DAS-7 scores and with added POBS predicting DAS-7 scores*

| Variable | Beta | *t value* | *P value* |
|---|---|---|---|
| Model 1 FSCRS | 0.30 | 0.241 | 0.811 |
| Model 1 OAS | -0.553 | -4.407 | <.001 |
| Model 2 FSCRS | 0.01 | 0.006 | 0.996 |
| Model 2 OAS | -0.210 | -1.352 | 0.181 |
| Model 2 POBS | -.466 | -3.329 | <.001 |

† includes the participants who were removed for the IPV satisfied and IPV dissatisfied group division.

## Discussion

This study sought to evaluate the extent to which sensitivity to betrayal differed between IPV survivors who have engaged in new and positive intimate relationships and those who have not, and how this related to self-criticism and shame. Results indicated that high betrayal sensitivity was present in all IPV survivors relative to controls, but that there was also some evidence of specificity, with IPV-dissatisfied group scoring higher on the subscales 'permanent change' and 'lack of trust' compared to both the IPV-satisfied and non-IPV groups, but not compared to the IPV-single group. It was anticipated that survivors of IPV who are in a relationship and satisfied would show less sensitivity to betrayal than those dissatisfied in a relationship or single. Although this was so for the "betrayal life change" and "lack of trust" subscales, the IPV satisfied group was not significantly different from IPV dissatisfied or IPV single groups for the subscales "Preoccupation with Betrayal events" and "Betrayal leading to traumatic responses". With regards to the self-criticism and shame hypothesis, only partial support was found. The IPV-dissatisfied group had significantly and similarly higher scores on all aspects of the scale ("inadequate self', "hated-self" and "reassured-self") compared to IPV-satisfied and controls, meaning they were more self-critical and less able to remind themselves of positive things about themselves. The IPV single group were also less able to reassure themselves than IPV-Satisfied and controls and were only significantly more self-critical in hated-self compared to controls. IPV Satisfied were only significantly different from controls on their ability to reassure themselves, meaning high self-criticism was specific to IPV-Dissatisfied and IPV single. For shame, all three IPV groups scored higher than the non-IPV group, but there were no significant differences within the three IPV groups.

These findings are consistent with research suggesting that betrayal trauma alters schemas about trust (Bistricky et al., 2017) and the way in which it impacts knowing and choosing who we do trust (Altmaier, 2016). The present study cannot determine whether aspects of low betrayal sensitivity in the IPV satisfied group has led to that better relationship, or whether the experience of being in a satisfactory relationship has helped survivors in the IPV satisfied group increase their trust and reduced betrayal sensitivity. Appraisals of trauma sequelae such as being permanently changed are common in survivors with PTSD and play a key role in predicting chronicity (Ehlers & Clark, 2000). Relationship satisfied survivors' positive relationships may have altered these appraisals, being in a satisfactory relationship may be taken as evidence by the survivor that the impact of the trauma has not led to complete permanent life change. Alternatively, one could hypothesise that the belief that others are trustworthy is essential to the formation of a successful intimate partnership, and that thus only the individuals with more positive beliefs about trusting others have been able to build such satisfactory relationships (Burton, 2009; St. Vil, Carter, & Johnson, 2018). Furthermore, believing that oneself and one's life is permanently changed could be an unhelpful belief to hold, acting as a barrier to building and maintaining good relationships. In fact, research suggests that a pessimistic view about people and the world can be a consequence of betrayal trauma (Freyd et al., 2005), however holding a more optimistic view may be essential to those fulfilling relationships.

It is possible (and would be unsurprising if true) that the dissatisfaction of survivors in their new relationships could be related to their increased difficulties with trust. It could also be evidence of misplaced trust, with some of those survivors having trusted their partners and entered into these relationships too quickly (Burton et al., 2009), and this may have negatively impacted their choice of partner or the relationship itself, leading to current dissatisfaction. Control strategies deployed in response to beliefs about being permanently

changed and others not ever being trustworthy may also lead to counter-productive behaviours, such as compartmentalised trust and enforced emotional distance between themselves and their partners to protect themselves from vulnerability to further IPV and future betrayals (Cherlin et al., 2004). Such strategies may be protective but may also generate relationship difficulties. Most likely this group requires finer-grained consideration accounting for different reasons for remaining single.

Participants in the single and dissatisfied groups demonstrated similar levels of sensitivity to betrayal as those of depressed patients and low MC in a recent study (Howkins, Millar, & Salkovskis, 2020). We know that depression is more likely in IPV survivors (Devries et al., 2013), potentially up to three times more (J. M. Golding, 1999). It could be that IPV survivors suffering from depression are more likely to negatively view their relationship as well as having an increased sense of betrayal, or simply that betrayal sensitivity is a generalised factor in the experience of mental health difficulties. Further research is needed to better understand this interplay.

**Limitations**

The sample included a high proportion of participants with postgraduate qualifications which perhaps exemplifies how the homophily principle can lead to a biased sample when recruiting through social networks (McPherson, Smith-Lovin, & Cook, 2001). However, it has also yielded data around a group of survivors who are less often seen in services and suggests that IPV is experienced across socio-economic status, challenging preconceptions that IPV is prevalent in lower social classes. This being a self-selecting group, it may be that those with academic or research experience may have been more interested in donating their time to research or found the study more accessible. Furthermore, due to the lack of data about survivors' traumatic experiences outside IPV (e.g.,

developmental trauma or adverse childhood experiences), it is not possible to know whether the findings could be related to this confound. Due to the small sample size and its lack of diversity across ethnicity (predominantly white) and exclusion of those with bipolar and psychosis diagnosis, one may argue that it is less reliable and generalisable to wider populations (Denscombe, 2010).

**Clinical Implications**

The findings add to evidence that survivors are fearful of future betrayals and therefore may need support rebuilding their confidence in knowing who and when to trust with a view to build new intimate partnerships. It also extends cognitive theory's research within the realm of interpersonal factors. Conceptualising the impact of complex trauma as sensitivity to betrayal, more specifically difficulties with trust, may help understand how we establish alliance with traumatised service users and how therapeutic ruptures can be avoided and repaired. Interventions should consider these appraisals around trust being permanently changed and seek to measure throughout treatment alongside the quality of their relationships. Furthermore, formulating interpersonal difficulties within a cognitive framework could provide new and helpful avenues to support cognitive therapies to include interpersonal factors as a target of intervention. These findings could also have implications for couple, family, and systemic therapy approaches. For instance, it may be useful to in therapy to highlight and explain aspects of sensitivity to betrayal to increase understanding between partners in a romantic relationship.

**Future research**

More research is needed into how sensitivity to betrayal manifests itself in survivors of different types of interpersonal traumas and experiences and affects their relationships. A

longitudinal study with IPV in all groups would elucidate the nature of the relationship between these beliefs and survivors' relationship status and satisfaction. Mediational studies would be good to evaluate the role of the relationship on sensitivity to betrayal and to explore associated appraisals. Evaluation of a focused psychological intervention, such as schema focused therapy targeting betrayal beliefs could help survivors develop satisfactory relationships after their traumatic experience of IPV, and in doing so provide a new avenue of supporting survivors in their long-term recovery. More investigation into the role of shame and self-criticism could inform therapeutic approaches and improve understanding of long-term recovery in IPV.

## Conclusion

This research suggests that betrayal sensitivity is a useful construct to conceptualise some of the barriers IPV survivors face when building new intimate relationships. Further research is still needed to better understand the underlying mechanisms with a view to developing interventions that can reduce barriers to positive relationships and support survivors with long term recovery.

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**Executive Summary**

# Betrayal and romantic relationships in domestic violence survivors

*Why were we interested in "domestic violence survivors' relationships"?*

- The quality of your relationships determines the quality of your life

- Survivors of domestic violence often face significant relationship consequences.

- Fear of revictimisation is a major concern for survivors.

- There are few long term studies with survivors of domestic violence which means that little is known about how they establish new intimate relationships

- However, qualitative research suggests that domestic violence affects trust in future relationships and can lead to fears of further betrayal.

*Why were we interested in "betrayal"?*

- Betrayal sensitivity is conceptualised as how sensitive someone is to the possible experience of further betrayal and the subsequent negative impact of such betrayals.

- Experience of betrayal can act as a barrier to forming new intimate partnerships.

- High sensitivity to betrayal may reduce the likelihood of fulfilling intimate relationships.

- There is evidence which suggests that prior experience of domestic violence can lead to high levels of sensitivity to betrayal, shame, and self-criticism and therefore may interfere with the initiation, development and maintenance of future intimate relationships.

*What was the aim of our research?*

- To examine levels of betrayal, shame, and self-criticism in female survivors of domestic violence.

- To evaluate whether survivors satisfied with their intimate relationships – as well as women without a history of domestic violence – are less sensitive to being betrayed compared to those dissatisfied with their relationships or single.

*What did we do?*

- We recruited three groups of domestic violence survivors with varying romantic relationship statuses: i) single; ii) in a relationship and not satisfied with the relationship quality; iii) in a relationship and satisfied with the relationship quality. We also recruited one group of adults without experience of domestic violence.
- We shared information about recruitment online (e.g. social media) and through charities in the community. Questions about their relationship status and experience of domestic violence were used to divide them into groups.
- Those who decided to take part then completed an online survey that included questionnaires about betrayal, shame and self-criticism.
- We compared the responses of the different groups.

*What did we find?*

- Survivors of domestic violence were more sensitive to betrayal than people without such experience.
- Survivors who reported being happy in their romantic relationships were less sensitive to betrayal than the other two groups of survivors (i.e., those who were unhappy in their relationships and those who were single) across two of the four subscales. They believed less that their experience had caused a life change and that others could not be trusted.

*What are the real-world implications?*

- Fear of future betrayals may affect survivors' ability to trust and form new intimate relationships.
- Professionals may find it helpful to assess betrayal sensitivity when helping survivors to rebuild their confidence in knowing when and who to trust. This could help them build new intimate partnerships.
- Interventions should target survivors' appraisals of trust and being permanently changed by the trauma, and measure progress in relationships.

- Understanding the impact of complex trauma as sensitivity to betrayal, specifically difficulties with trust, can help in establishing a therapeutic alliance with traumatised service users. It could help prevent and repair therapeutic ruptures.

*What are some limitations of our study?*

- We did not have a diverse sample in terms of ethnicity, and we had a lot of participants with postgraduate qualifications. Both could mean our findings are not representative of the general population.

- We need a bigger sample size to find out more as not all our groups were fully powered.

- We cannot confirm that betrayal sensitivity is only caused by the event or experience of domestic violence.

# Connecting Narrative

Undertaking three research projects with multiple supervisors made me reflect on the supervisor-supervisee relationship. I learned that there are many valuable qualities that a supervisor can bring to a project that may improve the finished product and/or the experience. There are individuals who are truly passionate about methodology who make you think and care about the process, helping you stay away from the task-based and efficiency mindset that we can all fall into due to the academic and clinical pressures of the research. The most incredible people also keep you connected to the why, the users, services and individuals that originally motivated this pursuit. The work is at its best when we engage with research methodology while holding our participants, service users, population in mind. We can enjoy it more meaningfully and experience flow, and we can produce work that is honest and purposeful. Ethical research for me also means work that aims to help others and stays away from self-centred pursuits of academic recognition and achievement. With that in mind, I chose three projects that stem from my primary motivation: to better understand the suffering humans experience when life's tragedies make it hard to maintain connections and experience love and belonging, and the loss and sacrifice that comes from the ache of not being able to reach others.

## Systematic Review of the Literature

I was inspired to conduct a literature review on the interpersonal consequences of trauma due to my previous experience working with survivors of trauma in various healthcare settings. My curiosity and indignation were peaked by a trainee who assertively explained that childhood trauma predicted adult domestic violence and future trauma. I wondered about the evidence supporting this narrative which seemed overly deterministic. Many survivors of adult interpersonal trauma that I had observed did not experience abuse

in childhood and thus fit this narrative. However, they were concerned with their relationships falling apart because of their victimisation. I wanted to explore whether our understanding of the survivors' experiences was skewed and to consider the unique impact of adult trauma on interpersonal functioning.

This was my longest project, and the greatest challenge of the review was developing a search strategy that would yield comprehensive results. The word "relationship" could not be used as it also serves to discuss associations between variables and therefore yielded indiscriminate results. The words "interpersonal" and "functioning" are often used in research that bears no relevance to this project. Therefore, the development of the strategy demanded I identify words associated with the hypothesised interpersonal outcomes of trauma. After four meetings with a librarian and several with my supervisor, I designed a strategy which I hoped would provide an overview of the literature.

The review taught me a lot about the quality of research and motivated me to further understand the mechanisms that underlie relational outcomes in survivors. This is already proving useful in my clinical work and therefore I plan to disseminate my findings via publication to help professionals better understand the interpersonal difficulties that may impact individuals' ability to access treatment.

**Theoretically Driven Research Project**

My interest in relational outcomes after trauma motivated both my SRL and my TDRP. I wanted to examine the relationship between interpersonally traumatic events and their relational outcome. I was curious to find out more about some of the beliefs that

might influence the ability to form and maintain relationships. Thankfully, with great supervision, I was able to develop a narrow project that would look at a specific concept.

Getting the project approved and through ethics was challenging. I was determined to work with a population that is often forgotten about due to fears around clinical responsibility from the system. My clinical and personal experience allowed me to be thoughtful and consider the research burden and risk of asking about trust and betrayal for this population. My tenacity was rewarded when I undertook recruitment, and many survivors were excited by the interest taken in the difficulties they face attempting to rebuild their lives. Individuals in support groups on social media were passionate about the project and said this was one of their main concerns and one that lacked attention in support services, mental health and research. This highlighted how important clinical research is, and I was pleased that people found the project relevant to their experiences. Doing this project has also informed my own clinical practice. I now increasingly think about how those interpersonal beliefs may come up in the therapeutic space and contribute to patients having impoverished support networks.

**Service Improvement Project**

The SIP was my first experience of thematic analysis. It was challenging to tackle new research methodology, and recruitment was difficult due to the COVID pandemic. Finally, it was hard to summarise in a publishable format the data obtained from interviewees who had shared their suffering and been emotional with me, and I wondered if I was honouring their voices sufficiently. I was lucky to have great supervision, which helped me appreciate the value of qualitative research and reflect on the process as well as my own bias.

It was exciting to develop a project which could lead to practical application. I found this work so engaging that I applied to work in this service, and now that I am, I hope to use my research findings to implement change. Through interviewing carers, I became aware of the sacrifices and losses they experience, and the potential for moral injury in social workers. Currently, I am contributing to improving service quality by using my findings and research skills to tailor and develop a service for adopters and kinship carers in Oxfordshire County.

**Hopes for future research**

Completing the research portfolio was challenging due to the difficulties posed by the COVID-19 pandemic, but it also allowed me to develop creativity, adaptability, and problem-solving skills. Despite the challenges, I found the experience of doing clinical research during training rewarding and I am happy I could produce meaningful work.

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# Appendices

## Appendix A – SLR: Full Search Strategy

**Search terms:**

1. **Interpersonal trauma**: (“interpersonal trauma" OR "CPTSD" OR "complex PTSD" OR DESNOS OR PTSS OR "sexual trauma" OR “relational trauma” OR “complex trauma”)
2. **Interpersonal functioning** (types of relationship, skill and difficulties, measures): ("interpersonal problem" OR "interpersonal functioning" OR "relationship pattern" OR "interpersonal skill" OR "marital quality" OR "relationship dynamic" OR "relational disturbance" OR "relationship outcome" OR "social function*" OR "social interaction*" OR "family relation*" OR "relationship quality" OR "relationship satisfaction" OR "significant other" OR "interpersonal relation*" OR "interpersonal interaction*" OR shame OR distrust OR abandonment OR "interpersonal schema" OR isolation OR commitment OR "couple therapy" OR marriage OR betrayal OR friendship OR intimacy OR trust OR attachment OR "borderline personality disorder" OR "Inventory of Interpersonal Problems" OR "Inventory of Self-Altered Capacities" OR "Social Adjustment Scale")
3. Limited to English and Human

(Combine: 1 AND 2 AND 3)

| **Inclusion** | **Exclusion** |
|---|---|
| Empirical quantitative research | Theoretical discussions and qualitative research (e.g., case studies, thematic analysis) |
| Peer reviewed journal or article | Not peer reviewed research ( e.g., dissertations or book) |
| English language and Humans | Not in English and animals |
| 18+ | Under 18 |
| Exposure or independent variable is adult interpersonal trauma:<br>Including medium to high betrayal trauma<br>The terminology interpersonal trauma was chosen over interpersonal violence to yield a more discreet set of results with a psychological focus. | Combat trauma or war, most of the reported childhood interpersonal trauma >50%<br>There is expected overlap between childhood and adult interpersonal trauma, however for the results to meaningfully speak to the impact of adult trauma, it is thought that childhood trauma should not be present in over half the population. |
| Setting and population<br><br>Community or clinical (e.g. complex PTSD or MDD populations) | Setting and population<br><br>Not specialised populations such as offenders, HIV, substance abuse, refugees, veterans, dysrepunia.<br>In specialised populations such as refugees there may be significant confounding factors that could explain the results beyond interpersonal trauma, thus making this not comparable to the body of evidence provided by other research. For instance, the precarious legal status with possibly an associated feeling of institutional betrayal, marginalisation and culture shock may all be factors that impact refugees interpersonal functioning beyond interpersonal trauma. Experiencing pain during sex (dysrepunia) may impact an individual's sexual and intimate relational functioning. |
| Comparison groups: no interpersonal or no trauma | Comparison group: not specialised population with medical health problem |
| Outcome or dependent variable is interpersonal functioning: (e.g., attachment, shame) | |

## Appendix B – SLR: Interpersonal Functioning Measures Summary

Eight studies looked at attachment. Five strictly dimensional measures of attachment avoidance and anxiety were included: Experience in Close Relationship self-

report questionnaire (ECR; Brennan et al., 1998) and variants (ECR-R; Fraley et al., 2000; ECR-S; Wei, Russell, Mallinckrodt, & Vogel, 2007) (3), Perceptions of Adult Attachment Questionnaire (PAAQ; Lichtenstein & Cassidy, 1991) (1), The Attachment Style Questionnaire (ASQ; Feeney et al., 1994) (1) and The Revised Adult Attachment Scale (RAAS; Collins, 1996) (Chinese version) (1). Three studies (Fowler et al., 2013, Wiltgen et al. 2015; Woodhouse et al., 2018) used the Relationship Questionnaire (RQ; Bartholomew & Horowitz, 1991), a 4-item measure, which can yield both dimensions and categories of secure and insecure attachment styles. All the above were relatively short self-report questionnaires (items ranging from 4 to 60) and focused on partner or close relationships.

Four studies investigated specific relationship functioning (e.g., mother-infant) (n=4) (Belford et al., 2012; Jaffe et al., 2019; Kobayashi et al., 2021; Kolk et al., 2021). When assessing parental representations of the child, one study (Kolk et al., 2021) chose a self-report questionnaire the Postpartum bonding questionnaire (PBQ; Brockington et al., 2001) which looks at perceptions of emotional bonding with the infant (or maternal feelings and views) at three months postpartum. The other study examined maternal feelings towards their child and their relationship with them before they are born with a semi-structured the Working Model of the Child Interview (WMCI; Zeanah, Benoit, Barton, & Hirschberg, 1996) (Kobayashi et al., 2021). They also measured attachment specifically to intimate partners (ASQ; Feeney et al., 1994) (Kobayashi et al., 2021) whilst the Life Events Checklist (Gray et al., 2004) was used categorically to determine relationship quality in terms of revictimisation or not (Jaffe et al., 2019). Finally, the relational health index aimed to assess relationship quality perception in three relationship domains (i.e., peers, mentor and community) (RHI; Liang et al., 2002) (Belford et al., 2012).

Studies also examined beliefs about others (e.g., trust) (n=4) (Jaffe et al., 2019; Lathan et al., 2021; Torres et al., 2013; Wright et al., 2010). The researchers mainly examined these distinct constructs by selecting specific subscales from validated measures/questionnaires: The Reliability and Trustworthiness of Others (RTO) in The Posttraumatic Maladaptive Beliefs Scale (PMBS; Vogt et al., 2012) (Jaffe et al., 2019); betrayal in the Traumatic Appraisals Questionnaire (TAQ; DePrince et al., 2010) (Lathan et al., 2021); Suspiciousness, Restricted Expression, Rejection, Intimacy Problems in the Dimensional Assessment of Personality Pathology-Basic Questionnaire (DAPP-BQ; Livesley & Larstone, 2008) (Torres et al., 2013); and safety, trust, intimacy in the Traumatic Stress Institute Belief Scale–Revision (TSIB; Pearlman, 1996) (Wright et al., 2010). It is worth noting that intimacy here refers to "*avoid[ing] attachment and intimacy; inhibited sexuality*" (Torres), and items like "*I hate to be alone*" (Self-Intimacy) and *"there are many people to whom I feel close and connected." (Other-Intimacy)* (Wright et al., 2010) respectively.

Additionally, one of the studies above (Lathan et al., 2021) also included a supplementary self-report questionnaire on trust the General Trust Scale (GTS; Yamagishi & Yamagishi, 1994) and its own measure of safety based on a three-item 5-point Likert scale generated by the study's authors. In a review of trust scales, the GTS was thought to mention faith in human nature and cautiousness, and be mostly applied to mixed, social, consumer and economic psychology.

Finally, four studies measured behavioural problems (e.g., social problem solving) (Bistricky et al., 2017; Reich et al., 2015; Torres et al., 2013; Woodhouse et al., 2018). Three used the following validated measures: Interpersonal Competence questionnaire (ICQ: Buhrmester, Furman, Wittenberg, & Reis, 1988), Social problem-solving inventory-revised

(SPSI-R; D'Zurilla et al., 2002), and restricted expression in the aforementioned DAPP-BQ. One study lifted a bespoke set of items (4) about emotional disclosure from a study by Bedard-Gilligan et al.'s (2012). They also used 6 items from the Social Acknowledgement scale (SAQ; Maercker & Muller's, 2004). Taken together the behavioural components in these studies considered different domains including emotional disclosure (Restricted Expression, Bedard-Gilligan's disclosure and ICQ), social problem-solving strategies (i.e., rational, avoidant or impulsive) (SPSI-R), and social recognition and disapproval (SAQ).

## Appendix C – SLR: Quality Appraisal Summary

All but on study were rated as fair (13), this was due to the correlational design of studies which meant they struggled to support a causal relationship. Only one longitudinal study was rated as good and looked at multiple time points, thus providing robust evidence for causality and (Jaffe et al., 2019).

### *Population and Recruitment*

Studies clearly set out their hypothesis and provided comprehensive descriptive information about study population. However, three failed to provide details about time of recruitment (Lathan et al., 2021; Sandberg & Refrea, 2022; Sandberg et al., 2010). Community studies recruited participants exposed to interpersonal trauma from the same setting as those non-exposed, though two differed in the community setting thus there could be additional unmeasured confounds (Bistricky et al., 2017; Reich et al., 2015).

### *Exposure to interpersonal trauma*

The measurement of the exposure (e.g., interpersonal trauma), varied substantially ranging from a single standardised self-report measure (12/15) to three more extensive and bespoke compilation of multiple assessment tools (Kolk et al., 2021; Reich et al., 2015; Wright et al., 2010). See Table 2. Such studies considered levels of exposure in terms of number of traumas, types, and relationship to the perpetrator. None unfortunately reported

time since the exposure aside from one which stipulated that IPV had taken place in the previous 12 month (Torres et al., 2013). Therefore, it is not possible to ascertain whether the time since the exposure is sufficient to notice an association nor is this discussed or acknowledged.

***Relational functioning outcomes***

All outcomes were measured with validated and reliable tools except for one (i.e., emotional disclosure; Woodhouse et al., 2018). The latter (Woodhouse et al., 2018) as well as two other studies, selected and reported only one of the subscales of their measure therefore increasing the risk of bias (i.e., avoidant attachment; Bistricky et al., 2017; i.e., betrayal; Lathan et al., 2021).

***Power and design***

Several studies capitalised on large cohort data and routine outcomes (Fowler et al., 2013; Wiltgen et al., 2015). Unfortunately, no studies appear to consider power calculations prior to recruitment. They all seemed to use convenience sample without justification though this was commented on in the discussion by some. Only one study was longitudinal and 76.6% of participants completed all follow-ups. All other were cross-sectional.

***Blinding***

All studies assessed both exposure and outcome through self-report measures except two (Kobayashi et al., 2021; Reich et al., 2015). This meant outcome scores were at a lower risk of bias due to an assessor who may or may not have been blinded to the exposure status of the participants. Participants whose data was from routine outcomes were blind to the research question (Fowler et al., 2013; Wiltgen et al., 2015). One study even determined allocation of the participants to studies after completion of data (Belford et al., 2012).

***Confounding variables***

Only seven studies collected data with a view to conduct an analysis to determine the impact of confounding variables though some raised this in their discussion. Some variables controlled included age (Sandberg et al., 2010; Torres et al., 2013), gender (Belford et al., 2012; Huang et al., 2017; Sandberg & Refrea, 2022), income (Jaffe et al., 2019; Sandberg et al., 2010), and other sociodemographic characteristics (e.g., ethnicity, maternal age, infant prematurity and education level; Kolk et al., 2021; i.e. marital status; Sandberg et al., 2010; Torres et al., 2013). Studies also looked at changes in relationship (Jaffe et al., 2019), continuous betrayal trauma (Belford et al., 2012), lifetime trauma, antenatal and depressive posttraumatic symptoms (Kolk et al., 2021), and depression severity (Torres et al., 2013).

## Appendix D – SLR: Quality Assessment Tool

## Appendix E – SLR and TDRP: Author Guidance – Journal of Interpersonal Violence

Manuscript Submission Guidelines:
*JIV* only publishes reports on individual studies in which the scientific method is applied to the study of some aspect of interpersonal violence. Research may use qualitative or quantitative methods. *JIV* does not publish reviews of research, individual case studies, or the conceptual analysis of some aspect of interpersonal violence.

Each manuscript must:

- be prepared using APA style, and be **no longer than 30 double-spaced pages**, including references, tables, and figures;
- include an abstract of 250-300 words that clearly and concisely summarizes the study questions, subjects, methods, findings and major implications;
- include a discussion of diversity as it applies to the reviewed research.*

*** Journal policy on addressing diversity in manuscripts:**

*JIV* requires all submissions to include a discussion of diversity as it applies to the reviewed research (e.g., nature of the sample, limitations of the measurement). The discussion should address the body of knowledge reviewed as it addresses or fails to address issues of diversity. Diversity concerns are not criteria for publication but must be addressed. The nature of the discussion and amount of space devoted to the discussion is the responsibility of the author(s).

*JIV* understands diversity to include all aspects of human differences such as socioeconomic status, race, ethnicity, language, nationality, sex, gender identity, sexual orientation, religion, geography, ability, age, and culture.

Diversity as a core value embodies inclusiveness, mutual respect, and multiple perspectives and serves as a catalyst for expanding knowledge and practice with all human beings. While science seeks knowledge that can be generalized, it must appreciate that specific findings, while important in understanding the unique experiences of individuals or groups, are not necessarily applicable to all.

**Invited Manuscripts on Addressing Diversity in IPV Research:**
Tajima, E. A. (2021). First, Do No Harm: From Diversity and Inclusion to Equity and Anti-racism in Interpersonal Violence Research and Scholarship. Journal of Interpersonal Violence, 36(11–12), 4953–4987. doi: https://doi.org/10.1177/08862605211012999
Bent-Goodley, T. (2021). Diversity in Interpersonal Violence Research. Journal of Interpersonal Violence, 36(11–12), 4937–4952. https://doi.org/10.1177/08862605211013003

All manuscripts are peer reviewed and should be submitted with a letter indicating that the material has not been published elsewhere and is not under review at another publication. **Manuscripts should be submitted electronically to http://mc.manuscriptcentral.com/jiv** where authors will be required to set up on

online account on the SageTrack system powered by ScholarOne. Inquiries may be made by email at JIV@u.washington.edu.

Authors who would like to refine the use of English in their manuscripts might consider using the services of a professional English-language editing company. We highlight some of these companies at http://www.sagepub.com/journalgateway/engLang.htm.

Please be aware that SAGE has no affiliation with these companies and makes no endorsement of them. An author's use of these services in no way guarantees that his or her submission will ultimately be accepted. Any arrangement an author enters into will be exclusively between the author and the particular company, and any costs incurred are the sole responsibility of the author.

Please note:

*JIV* does not respond to author inquiries regarding the interest of the journal in their manuscript or on the suitability of their manuscript for *JIV*. The mission and parameters of *JIV* are clearly stated above and *JIV* assumes that authors are in the best position to know if their work is consistent with the aims and scope of the journal.

**Manuscript Preparation**

Manuscripts should be prepared using the APA Style Guide, and should be **no longer than 30 double-spaced pages, including references, tables, and figures**. (Brief Notes should be no longer than 12 double-spaced pages, inclusive.) Text must be in 12-point Times New Roman font. Block quotes may be single-spaced. Manuscripts must include margins of 1 inch on all sides and pages must be numbered sequentially. All files should be in Word (.docx or .doc).

The manuscript should include five major sections (in this order): Title Page, Abstract, Main Body (anonymized, with all author names and identifying information removed for peer review), References, and Author Biographies.

**Sections in a manuscript may include the following (in this order):** (1) Title page, (2) Abstract, (3) Keywords, (4) Text, (5) Notes, (6) References, (7) Tables, (8) Figures, (9) Appendices, and (10) Author Biographies.

**1. Title page must be uploaded as a separate file. Please include the following:**

- Full article title
- Acknowledgments and credits
- Each author’s complete name and institutional affiliation(s)
- Grant numbers and/or funding information
- Conflict of interests, if any
- Corresponding author (name, address, phone/fax, e-mail)

**2. Abstract.** Copy and paste the abstract (250 to 300 words) into the space provided, headed by the full article title. Omit author names. Abstract must clearly and concisely summarize the study questions, subjects, methods, findings, and major implications.

**3. Keywords.** 5-7 keywords must be included in the manuscript.

**4. Text.** Begin text headed by the full article title. Text must be anonymized, with all author names and other identifying information removed, for peer review.

**a. Headings and subheadings.** Subheadings should indicate the organization of the content of the manuscript. Generally, three heading levels are sufficient to organize text.

Level 1: centered, boldface, upper & lowercase
Level 2: flush left, boldface, upper & lowercase
Level 3: indented, boldface, lowercase paragraph heading ending with a period
Level 4: indented, boldface, italicized, lowercase paragraph heading ending with a period
Level 5: indented, italicized, lowercase paragraph heading ending with a period

**b. Citations.** For each text citation there must be a corresponding citation in the reference list and for each reference list citation there must be a corresponding text citation. Each corresponding citation must have identical spelling and year. Each text citation must include at least two pieces of information: author(s) and year of publication. Following are some examples of text citations:

**(i) Unknown Author:** To cite works that do not have an author, cite the source by its title in the signal phrase or use the first word or two in the parentheses. For example, “The findings are based on the study of students learning to format research papers” ("Using XXX," 2001)
**(ii) Authors with the Same Last Name:** Use first initials with the last names to prevent confusion. For example, “L. Hughes, 2001; P. Hughes, 1998.”
**(iii) Two or More Works by the Same Author in the Same Year:** For two sources by the same author in the same year, use lowercase letters (a, b, c) with the year to order the entries in the reference list. The lower-case letters should follow the year in the in-text citation. For example, “Research by Freud (1981a) illustrated that…”
**(iv) Personal Communication:** For letters, e-mails, interviews, and other person-to-person communication, citation should include the communicator's name, the fact that it was personal communication, and the date of the communication. For example, E. Clark, personal communication, January 4, 2009. Do not include personal communication in the reference list.
**(v) Unknown Author and Unknown Date:** For citations with no author or date, use the title in the signal phrase or the first word or two of the title in the parentheses and use the abbreviation "n.d." (for "no date"). For example, “The study conducted by the students and research division discovered that students succeeded with tutoring” (Tutoring and APA, n.d.).

**5. Notes.** If explanatory notes are required for your manuscript, insert a number formatted in superscript following almost any punctuation mark. Footnote numbers should not follow dashes ( — ), and if they appear in a sentence in parentheses, the footnote number should be inserted within the parentheses. The footnotes should be added at the bottom of the page after the references. The word “Footnotes” should be centered at the top of the page.

**6. References.** Basic rules for the reference list:

- The reference list should be arranged in alphabetical order according to the authors' last names.
- If there is more than one work by the same author, order them according to their publication date – oldest to newest (therefore a 2008 publication would appear before a 2009 publication).
- When listing multiple authors of a source use "&" instead of "and."
- Capitalize only the first word of the title and of the subtitle, if there is one, and any proper names – i.e., only those words that are normally capitalized.
- Italicize the title of the book, the title of the journal/serial and the title of the web document.
- Manuscripts submitted to JIV should strictly follow the current APA style guide.
- Every citation in text must have the detailed reference in the Reference section.
- Every reference listed in the Reference section must be cited in text.
- Do not use "et al." in the Reference list at the end; names of all authors of a publication should be listed there.

Here are a few examples of commonly found references. For more examples, please check the APA style guide:

**Books:**

*Book with place of publication:* Airey, D. (2010). *Logo design love: A guide to creating iconic brand identities.* Berkeley, CA: New Riders.

*Book with editors & edition:* Collins, C., & Jackson, S. (Eds.). (2007). *Sport in Aotearoa/New Zealand society.* South Melbourne, Australia: Thomson.

*Book with author & publisher are the same:* MidCentral District Health Board. (2008). District annual plan 2008/09. Palmerston North, New Zealand: Author.

*Chapter in an edited book:* Dear, J., & Underwood, M. (2007). What is the role of exercise in the prevention of back pain? In D. MacAuley & T. Best (Eds.), *Evidence-based sports medicine* (2nd ed., pp. 257-280). Malden, MA: Blackwell.

**Periodicals:**

*Journal article with more than one author (print):* Gabbett, T., Jenkins, D., & Abernethy, B. (2010). Physical collisions and injury during professional rugby league skills training. *Journal of Science and Medicine in Sport*, 13(6), 578-583.

*Journal article – 8 or more authors:* Crooks, C., Ameratunga, R., Brewerton, M., Torok, M., Buetow, S., Brothers, S., … Jorgensen, P. (2010). Adverse reactions to food in New Zealand children aged 0-5 years. *New Zealand Medical Journal*, 123(1327). Retrieved from http://www.nzma.org.nz/journal/123-1327/4469/

**Internet Sources:**

*Internet – no author, no date: Pet therapy. (n.d.). Retrieved from htttp://www.holisticonline.com/stress/stress_pet-therapy.htm*

*Internet – Organisation / Corporate author: SPCA New Zealand. (2011). Your dog may be dying from the heat [Press release]. Retrieved from*

*http://www.rnzspca.org.nz/news/press-releases/360-your-dog-may-be-dying-...*

**Examples of various types of information sources:**

*Act (statute / legislation): Copyright Act 1994. (2011, October 7). Retrieved from http://www.legislation.govt.nz*

*Blog post: Liz and Ellory. (2011, January 19). The day of dread(s) [Web log post]. Retrieved from*

*http://www.travelblog.org/Oceania/Australia/Victoria/Melbourne/St-Kilda/...*

*Brochure / pamphlet (no author): Aging well: How to be the best you can be [Brochure]. (2009). Wellington, New Zealand: Ministry of Health.*

*Conference Paper: Williams, J., & Seary, K. (2010). Bridging the divide: Scaffolding the learning experiences of the mature age student. In J. Terrell (Ed.), Making the links: Learning, teaching and high quality student outcomes. Proceedings of the 9th Conference of the New Zealand Association of Bridging Educators (pp. 104-116). Wellington, New Zealand.*

*DVD / Video / Motion Picture (including Clickview & Youtube): Gardiner, A., Curtis, C., & Michael, E. (Producers), & Waititi, T. (Director). (2010). Boy: Welcome to my interesting world [DVD]. New Zealand: Transmission.*

*Magazine: Ng, A. (2011, October-December). Brush with history. Habitus, 13, 83-87.*

*Newspaper article (no author): Little blue penguins homeward bound. (2011, November 23). Manawatu Standard, p. 5*

*Podcast (audio or video): Rozaieski, B. (2011). Logan cabinet shoppe: Episode 37: Entertainment center molding [Video podcast]. Retrieved from http://blip.tv/xxx*

*Software (including apps): UBM Medica.(2010). iMIMS (Version1.2.0) [Mobile application software].Retrieved from http://itunes.apple.com*

*Television programme: Flanagan, A., & Philipson, A. (Series producers & directors). (2011). 24 hours in A & E [Television series]. Belfast, Ireland: Channel 4.*

*Thesis (print): Smith, T. L. (2008). Change, choice and difference: The case of RN to BN degree programmes for registered nurses (Master's thesis). Victoria University of Wellington, Wellington, New Zealand.*

*Thesis (online): Mann, D. L. (2010). Vision and expertise for interceptive actions in sport (Doctoral dissertation, The University of New South Wales, Sydney, Australia). Retrieved fromhttp://handle.unsw.edu.au/1959.4/44704*

*Non-English reference book, title translated in English: Real Academia Espanola. (2001). Diccionario de la lenguaespanola [Dictionary of the Spanish Language] (22nded.). Madrid, Spain: Author*

***IMPORTANT NOTE:*** To encourage a faster production process of your article, you are requested to closely adhere to the points above for references. Otherwise, it will entail a long process of solving copyeditor's queries and may directly affect the publication time of your article. In case of any question, please contact the journal editor at JIV@u.washington.edu.

**7. Tables.** They should be structured properly. Each table must have a clear and concise title. When appropriate, use the title to explain an abbreviation parenthetically, for example, Comparison of Median Income of Adopted Children (AC) v. Foster Children (FC).

**8. Figures.** They should be numbered consecutively in the order in which they appear in the text and must include figure captions. Figures will appear in the published article in the order in which they are numbered initially. The figure resolution should be at least 300dpi at the time of submission.

**IMPORTANT:** PERMISSION - The author(s) are responsible for securing permission to reproduce all copyrighted figures or materials before they are published in *JIV*. A copy of the written permission must be included with the manuscript submission.

**9. Appendices.** They should be lettered to distinguish from numbered tables and figures. Include a descriptive title for each appendix (e.g., "Appendix A. Variable Names and Definitions"). Cross-check text for accuracy against appendices.

**10. Author Biographies.** Author(s) are required to send a 40-60 word biography for publication at the end of the article. A sample biography is given below:

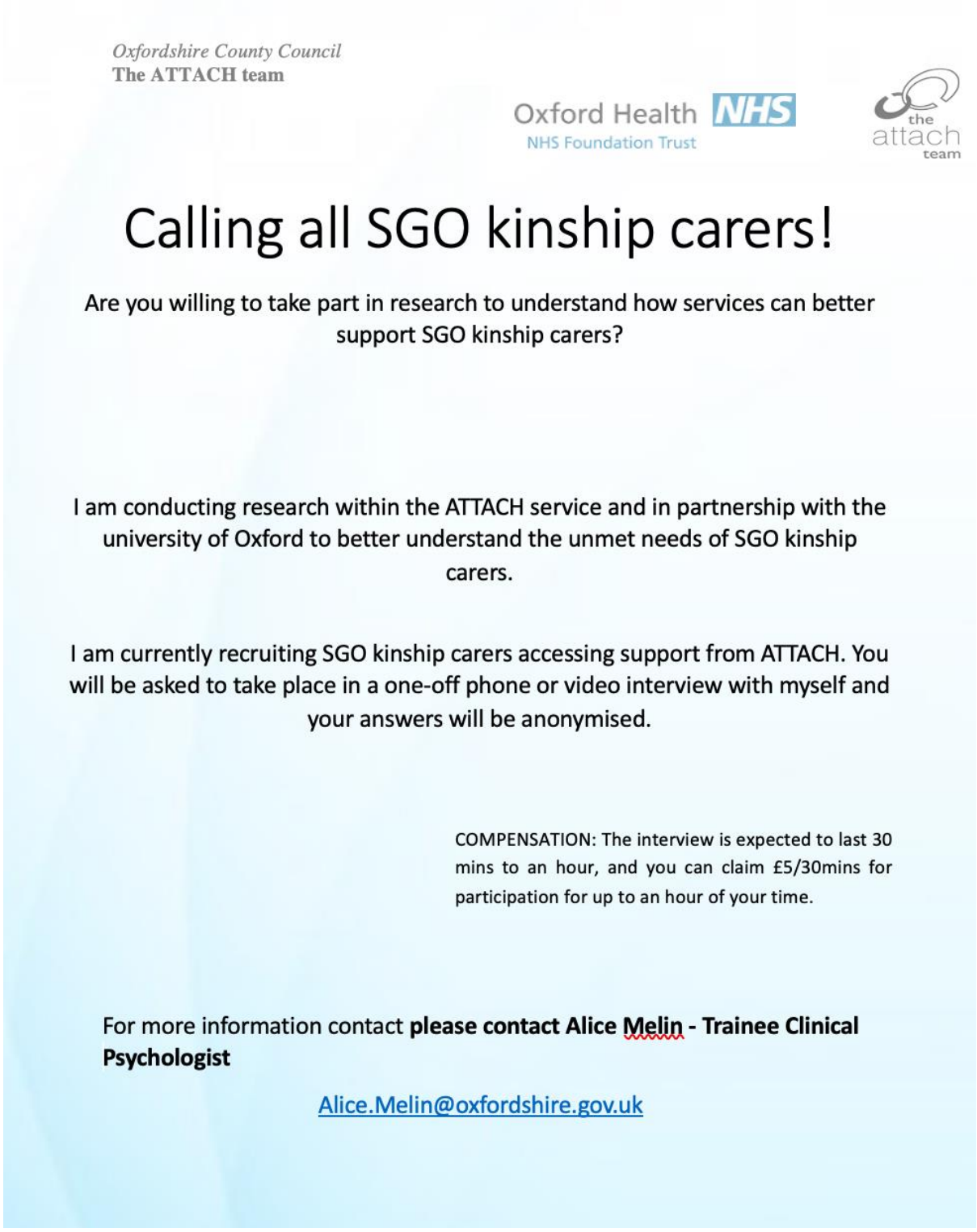
**Jessica Shaw**, PhD, is an Assistant Professor in the School of Social Work at Boston College. Her research focuses on community responses to sexual assault and emphasizes improving community systems through collaborative, multidisciplinary efforts. She is interested in using evaluation as a tool to initiate and support policy-level change and improvement and in identifying mechanisms to translate research into practice.

## Appendix F – SIP: Demographic Information

**Table 1.** *Demographic Information for Interview Participants*

| **Participant** | **Current age** | **Gender** (F for female, M for male) | **Caring alone or with a partner** (age if known, gender) | **Number of SGO children** (number of additional children <18 living at home) | **Age of SGO child** (years) | **Gender of SGO child** | **Ethnicity of carer** | **Relationship to child** |
|---|---|---|---|---|---|---|---|---|
| Emily & Rebecca | 60s & 40s | F and F | Solo | 2 | 14 and 9 | M and F | white British | grandmother and aunt |
| Clara | 61 | F | Couple (unknown, Male) | 1 | 8 | M | white British | great aunt |
| Sarah | 68 | F | Solo | 1 | 12 | F | white British | grandmother |
| Laura | 53 | F | Couple (74, M) | 2 | 7 and 5 | M and F | white British | grandmother and grandfather |
| Steve & Terry | 48 and 31 | M and F | Couple | 2 (3) | 1 and 4 | F and F | white British | grandfather and wife |

**Appendix G – SIP: Digital Flyer**



## Appendix H – SIP: Participant Information Sheet

### *1. Why is this research being conducted?*

Current evidence tells us that children develop as part of a system and healthy development is dependent on the wellbeing of the systems around them. These systems include family, school and the broader community. Family systems vary greatly and one type of family system that appears less frequently in the literature is kinship or special guardianship families. Special guardianships have become more common, but concerns have been raised about insufficient support for SGO carers. In addition, the lack of information around the needs of this group has made it hard for existing services to come up with tailored solutions for this population.

From existing research and anecdotal evidence, we understand that it may be especially hard for kinship carers to prioritise their well-being when they lack support and have become carers due to often a dramatic change or a long-standing issue that has left them exhausted. When there is too much stress, carers may be less able to understand his/her child's thoughts and feelings due to feeling overwhelmed with their own experiences of stress. The ability to hold another's thoughts, feelings and needs in mind is known as reflective functioning and is a skill thought to be key to managing behavioural issues, fostering attachment, and preventing placement breakdown. Reflective functioning can be significantly impaired by chronic stress and so supporting carers to manage life stresses and preserve reflective functioning is an area that receives lots of attention within the adoption and fostering literature but may be currently under-addressed for kinship carers.

This research seeks to investigate the unmet needs of kinship SGO carers in terms of wellbeing, parenting, social support and social care to improve the provision of services delivered by the ATTACH team by interviewing carers on the below topics:

- Emotional wellbeing and coping with new circumstances
- Responding to complex needs
- Relationship history with services
- Contact with (child's) birth parents and views on relationship role with the child

### *2. Why have I been invited to take part?*

You have been invited to take part in this research because you are a kinship SGO carer who is open to, or working with, the ATTACH service.
**If you would like to take part please contact Alice Melin - Trainee Clinical Psychologist**
Alice.melin@oxfordhealth.nhs.uk

### *3. Do I have to take part?*

No. You can ask questions about the research before deciding whether to take part. If you do agree to take part, you may withdraw yourself from the study by advising the researcher of this decision at any time, without giving a reason, and it will not in any way affect access to services provided by the ATTACH team or Oxfordshire County Council.

### *4. What will happen to me if I take part in the research?*

If you decide you would like to take part in this research, you will be invited to attend one interview.

When you arrive, I will talk you through the study procedure and give you the chance to ask any questions. If you are still happy to take part, I will ask you to confirm this by saying so and providing written consent.

If you are happy to take part in the research, you will be interviewed either by

- video (via Microsoft Teams),
- by phone or
- in person at our offices in Nash Court, 4440 John Smith Drive, Oxford Business Park South, Cowley, Oxford, OX4 2RU.

The interview should take approximately 30 minutes to an hour. We will ask a set of open questions about your experience of the service, we will have prompts available if needed. You can ask to pause or stop the interview at any time. There will be no follow-ups.
With your consent, I would like to audio or video record you during our interview (as appropriate to the medium of communication) so that we can have an accurate recording of our discussion. Audio recordings will be transcribed (typed up) within one week of the interview and the audio recordings will then be deleted to maintain an anonymous record of our conversation.

### *5. Are there any potential risks in taking part?*

The study may involve answering sensitive questions about your experience of becoming a kinship carer.
You will be provided with a debrief page or email (depending on how we do the interview) at the end of the interview letting you know that you can speak to members of the team if you need support.
If, during the interview, concerns are raised regarding your safety or the safety of others, the researcher may need to share this information with your clinician or outside agencies. If this needs to happen, this will be communicated to you.

### *6. Are there any benefits in taking part?*

This project aims to support ATTACH to provide a good service to kinship carers. We will use the information provided to shape the service with a view to more effectively meet the needs of carers like you. Many people who have completed similar research also report that it can be helpful to talk through their experiences and to have a space to think about the things that are going well as well as anything they would like to be different.

### *7. Expenses and payments*

You can claim £5/30mins for participation for up to an hour of your time.

### *8. What happens to the data provided?*

The information you provide during the study is the **research data**.
Data from all participants will be anonymised so that it is not possible to identify any individual. The data from the group of participants as a whole will be analysed, such that no individual data is reported. The qualitative data will come from interviews stored anonymously in transcribed form.

Informed consent will be sought from staff to take part in focus groups and service users in semi-structured interviews and will be documented.
Annelies Henshall Children's Principal Social Worker, Dr Laura Ogi Clinical Lead for the Residential and Edge of Care Service & Family Solutions and Assessment Teams at Oxfordshire County Council and Dr Claire Holdaway, Consultant Clinical Psychologist, Attach Team Oxfordshire County Council are responsible for ensuring that all data collection and management adhere to governance policies and procedures.
Data will be collected and entered onto a password protected database and stored anonymously on an encrypted device and data files will be backed up on the Local Authority server using a secure VPN network connection. Audio files will be kept on an encrypted and password protected iPad/Dictaphone until transcribed and then deleted. In line with information governance, data will be kept for a month after it is presented for completion of the doctoral thesis (VIVA) before being destroyed, the estimated for this is in summer of 2022.

The researcher (Alice Melin) and research supervisors (Dr Catherine Naysmith and Dr Sasha Walters) will have access to the research data.

I/We would like your permission to use direct quotes anonymously in any research outputs.

**9.** ***Will the research be published?***

The findings of the research may be shared in the ATTACH service team meeting, relevant journals, and conferences.
On successful submission of the thesis, it will be deposited both in print and online in the University archives to facilitate its use in future research. If so, the thesis will be openly accessible.

***10. Who has reviewed this study?***

This study has been reviewed and received ethics clearance through, Oxfordshire County Council.

***11. Who do I contact if I have a concern about the study or I wish to complain?***

If you have a concern about any aspect of this study, please contact Alice Melin alice.melin@oxfordshire.gov.uk or Dr Catherine Naysmith catherine.naysmith@oxfordshire.gov.uk, and we will do our best to answer your query. I/we will acknowledge your concern within 10 working days and give you an indication of how it will be dealt with. If you remain unhappy or wish to make a formal complaint, please contact Dr Sasha Walters, Principal Clinical Psychologist, The Oxford Institute of Clinical Psychology Training and Research, who will seek to resolve the matter as soon as possible:

Contact details
Dr Sasha Walters, Principal Clinical Psychologist
The Oxford Institute of Clinical Psychology Training and Research
Sasha.walters@hmc.ox.ac.uk

***12. Data Protection***

Oxfordshire city council is the data controller with respect to your personal data, and as such will determine how your personal data is used in the study. The council will process your personal data for the purpose of the research outlined above. Research is a task that is performed in the public interest.
Further information about your rights with respect to your personal data is available from

Access to data and information | Oxfordshire County Council

### *13. Further Information and Contact Details*

If you would like **to take part** or discuss the research with someone beforehand (or if you have questions afterwards), please contact:

**Alice Melin – Trainee Clinical Psychologist**
Alice.melin@oxfordshire.gov.uk

Supervised by **Dr Catherine Naysmith**
Principal Clinical Psychologist
catherine.naysmith@oxfordshire.gov.uk
*Oxfordshire County Council*
**The ATTACH team**
Nash Court
4440 John Smith Drive
Oxford Business Park South
Cowley, Oxford
OX4 2RU
*Team telephone number: 01865 897083*




**& Supervised by Dr Sasha Walters**
Principal Clinical Psychologist
Sasha.walters@hmc.ox.ac.uk
Oxford Health Specialist Psychological Intervention Centre (OHSPIC)
The Oxford Institute of Clinical Psychology Training and Research

**Appendix I – SIP: Consent Script**

**CONSENT SCRIPT FOR EMAIL AND MS FORMS**

Obtaining informed consent from research participants via email
Please read the statements below. If you are happy with all of the statements, please initial next to each statement and sign at the bottom and send it to me alice.melin@oxfordhealth.nhs.uk . This will be considered to constitute giving your consent to participate in the study.
If you have any questions about the research or the statements below, please do not hesitate to contact me.

I confirm that I have read and understand the information sheet for the study *Mapping the needs of special guardianship orders (SGO) kinship carers (ATTACH team Oxfordshire)*
I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without any adverse consequences or penalty.
I understand what will happen to my data.
I give the researcher(s) permission to interview me, video or audio record me.
I give permission for the researcher(s) to quote me directly anonymously.
I agree for anonymised research data collected in this study to be used in future research publications.
I am happy to take part in the research.

**Appendix J – SIP: Debrief**

# DEBRIEF

## Mapping the needs of kinship carers with Special Guardianship Orders (SGO) ATTACH team Oxfordshire

Thank you for taking part in this study, we really appreciate your help.
To show our appreciation for your ***dedication, time and effort***, we would like to reimburse you. You can claim £5/30mins for participation up to an hour of your time.
This research sought to investigate the unmet needs of kinship SGO carers in terms of wellbeing, parenting, social support and social care to improve the provision of services by the ATTACH team.
The answers to the questions we asked you will help us to find out about the needs of SGO kinship carers in relation to the following themes:

- Emotional wellbeing and coping with new circumstances
- Responding to complex needs
- Relationship history with services
- Contact with (child's) birth parents and views on relationship roles with the child

So thank you!

**What happens next?**

To remind you, data from all participants will be anonymised so that it is not possible to identify any individual. The data from the group of participants will be analysed as a whole. The qualitative data will come from interviews stored anonymously in transcribed form.
Data will be collected and entered onto a password protected database and stored anonymously on an encrypted device and data files will be backed up on the Local Authority server using a secure VPN network connection. Audio files will be kept on an encrypted and password protected iPad/Dictaphone until transcribed and then deleted. In line with information governance, data will be kept for a month after it is presented for completion of the doctoral thesis (VIVA) before being destroyed, the estimated for this is in summer of 2022.
Many people who contribute to this kind of research enjoy the process but for some, talking about experiences and feelings related to caring for a child can be challenging. If you have experienced any distress that you would like to talk about in more detail please contact your ATTACH worker.

**Further advice and support**

The NHS can help if you think you are suffering from a mental illness. There are also many charities who can provide advice, emotional and practical support. If you are concerned about your mental health, we encourage you to speak to your GP who can then refer you for further specialist help.

**Sources of advice and support**

1. Your General Practitioner
2. NHS 111
3. Helplines:
    a. The Samaritans 116 123
    b. SANE 0300 304 7000 or http://www.sane.org.uk/

**Further questions**

If you have a concern about any aspect of this study, please contact Alice Melin Alice.melin@oxfordshire.gov.uk or Dr Catherine Naysmith catherine.naysmith@oxfordshire.gov.uk, and we will do our best to answer your query. I/we will acknowledge your concern within 10 working days and give you an indication of how

it will be dealt with. If you remain unhappy or wish to make a formal complaint, please contact Dr Sasha Walters, Principal Clinical Psychologist, The Oxford Institute of Clinical Psychology Training and Research, who will seek to resolve the matter as soon as possible.

Contact details
Dr Sasha Walters, Principal Clinical Psychologist
The Oxford Institute of Clinical Psychology Training and Research
Sasha.walters@hmc.ox.ac.uk

**Appendix K – SIP: Procedure**

# PROCEDURE

Participants expressed interest to be interviewed were either provided with details of the primary researcher (AM) or consented to have their contact details shared with them and were contacted by them. Participants were screened according to inclusion/exclusion criteria.

Participants were provided with an information sheet before they consented to take part in the study. Informed consent was made explicit and recorded through an online MS form prior to participation or verbally at the start of the interview. Participants were offered compensation for their time (£10/hour), and the procedure for this was explained to them though all participants declined. They were made aware that the interview would take 30 mins to an hour, had 6 parts with open and prompting questions and would be recorded on MS Teams. At the end of the interview, participants were sent a debrief email in which they were advised to contact their clinician for support.

**Appendix L – SIP: Interview Schedule**

## Interview schedule

**Relationship to the service:** What has been your experience of attach?

- ***Prompt:*** *Was it easy to talk to the staff? Do you feel you could be open?*
- ***Prompt:*** *Did you want to come? Where you worried about engaging with the service?*
- ***Prompt:*** *What were your reasons/expectations and were they met?*
- ***Prompt:*** *If it was it difficult/positive, why was that?*

**Relationship with birth parents**

- **Prompt:** *What was/is your relationship with the birth parents of the child for whom you care?*
- **Prompt:** *Are you currently having contact with them?*

**Relational position towards the child:** How words do you use to describe your relationship to the child for whom you care to others?

- ***Prompt:*** *Do you feel confident explaining this relationship to people?*
- ***Prompt:*** *Does this change depending on who you are talking to? Does that change depending on who they are talking to?*
- *How does your child describe this relationship?*
- ***Prompt:*** *Does that change depending on who they are talking to?*

**Complex needs of the child:** How do you feel you are managing your responsibilities?

- ***Prompt:*** *Do you feel you are confident in managing the emotional needs of the child?*
- ***Prompt:*** *Do you feel you understand them?*
- ***Prompt:*** *Do you feel you have the skills and are able to meet them?*

**Emotional impact of caring for the child:** What has been the impact of your new caring position on you?

- ***Prompt:*** *What was it like when XX first came into your care?*
- ***Prompt:*** *What was going on for you at the time? What was difficult about that?*
- ***Prompt:*** *How have you been feeling since the child has been placed in your care? Did you feel able to share these circumstances with others and did you feel supported?*
- ***Prompt:*** *What is it like now? How are you managing alongside your other caring responsibilities?*
- ***Prompt:*** *What impact has it had on your relationships – social and romantic?*

**Change ideas:** If you had one suggestion for something to be done differently in the service, what would it be?

- ***Prompt:*** **Could ATTACH help with XXXX (here it may be helpful to reference some of the difficulties that have been described above such as managing priorities, emotional wellbeing, building trust, etc…)**
- ***Prompt:***
  *Prompt: What do you wish Attach could offer that it is not currently?*

## Appendix M – SIP: Quotes

| Superordinate themes | Subordinate themes | Key Messages & Quotes | Prevalence * |
|---|---|---|---|
| Navigating services and help-seeking | Accessing support in a complex system | *I don't feel like I can ask, really, I don't know who to ask.* | Sarah |
| | | *quite hard actually to know what the different teams offer…*<br>*you shouldn't have to, I know it sounds awful, but I suppose beg for it* | Emily & Rebecca<br>Sarah |
| | | *something that's offered to people sooner, not when they get to a crisis point* | Laura |
| | | *'cause it's a lot to have took on and we feel we're sort of pulling teeth in getting support* | |
| | | <u>Psychological support is unknown</u> | |
| | | *I didn't because I didn't really know what I could do and that so I went in with an open mind* | Emily & Rebecca |
| | | *really no expectations* | Sarah |
| | | *we did not really know what we was gonna get* | Steve & Terry |
| | | *any expectations 'cause we didn't really know what was out there* | Laura |
| | Available support is inappropriate or insufficient | <u>Legal</u> | |
| | | *we were let down a little bit in that we didn't realize there wasn't gonna be any support, whereas if we had gone fostering or adoption, we might have been entitled to a little bit of respite here and there.* | *Laura* |
| | | *all this other paperwork and meetings.* | *Steve & Terry* |

| | | | |
|---|---|---|---|
| | | *we feel that the SGO didn't help… nobody's there to give you a rest if you need it.* | *Emily & Rebecca* |
| | | <u>Social services</u> | Laura |
| | | *we pretty much been dropped by social services before that. Because the children weren't in need of anything* | Emily & Rebecca |
| | | *I lost my social worker straight away. I didn't see her once the court case had been sorted and there's just nobody* | Steve & Terry |
| | | *[Social workers] it make a big difference in terms of dynamics and managing it. We were meant to sign the children in need off on Thursday. And now we've decided to keep it for the extra six weeks* | Laura |
| | | <u>Other services</u><br>*there doesn't seem to be anything regular for SGOs fosterers…going through similar stuff and what little tips they've got as to how they've dealt with issues* | |
| | Support systems filling the gaps | <u>School</u><br>*I got help from the school* | Clara |
| | | *school have been absolutely fantastic…When they're at school we enjoy that bit of freedom* | Laura<br>Sarah |
| | | *[School] picked up that there was something not quite right and they recommended CAMHS and Attach for me.* | Emily & Rebecca |
| | | *It [the referral] was all to do with school* | |
| | | <u>Family</u> | Steve & Terry |
| | | *The only person really here we've ever had support with childcare is Steve's mum who's really well known by the children.* | Emily & Rebecca |
| | | *(people asked) do you get respite? Or who's your respite? You used to say me (daughter) didn't you? Who did it? Me* | Clara |

| | | | |
|---|---|---|---|
| | | *I speak to my mom as well…the two most important people, we've actually lost (other relatives...* | Sarah |
| | | *That's another reason why the group was so good 'cause I could say any of those things and they're all nodding…It's nice to know that I'm not the only one with this sort of thing* | Steve & Terry |
| | | It was also nice to be in a room with other people who were in the same situation. | Emily & Rebecca |
| | | <u>Need for professional reassurance</u><br>*I needed to talk things over to let me know that I was basically doing alright* | Steve & Terry<br>Laura |
| | | *I think we know what needs to be done, but sometimes it's the best way to go about it.* | |
| | | *And somebody from an authority being there just for guidance or something.* | |

| **Superordinate themes** | **Subordinate themes** | **Key Messages & Quotes** | **Prevalence *** |
|---|---|---|---|
| **Negotiating new family structure and relationships** | Naming the role | <u>For the carer</u><br>*to us he's our son* | Clara |
| | | *I'm Nanny, but I'm like a mummy to you* | Laura |
| | | *I'm Nan … but you have to be a carer… I'm auntie* | Emily & Rebecca |
| | | *I've always been her Nan and I always will be* | Sarah |
| | | <u>For the child</u> | |
| | | *he will actually say 'my mum's the best'* | Clara |
| | | *They did say can we call you Mummy and Daddy?* | Laura |
| | | *I live with Nanny and Nanny looks after me* | Emily & Rebecca |
| | | *the other children call me mummy and so she started calling me Mummy as well, which upset her biological mum* | Steve & Terry |
| | | <u>For others</u> | Clara |

| | | | |
|---|---|---|---|
| | | *No, I'm his mum, but I am not his tummy Mommy*<br><br>*I make it clear that I'm her Nan and guardian as well*<br><br>*We both say we're their grandparents*<br><br>*I've got to a stage now where I haven't felt the need to explain.*<br><br>*he's got like this little passport thing …and it's got obviously MUM and mum's name: Nan* | Sarah<br><br>Laura<br><br>Steve & Terry<br><br>Emily & Rebecca |

| **Superordinate themes** | **Subordinate themes** | **Key Messages & Quotes** | **Participant** |
|---|---|---|---|
| The challenge of caring in adversity | Adversity as the context of the SGO | *they remember that Mommy didn't feed them and left them alone in the flat and that Mummy sent them to school on their own.*<br>*the relationship was as good as it can be with a drug addict*<br>*a lot of the things that have happened, domestic violence and stuff.*<br><br>*their mother, who was a heroin addict… they were living in muck. They were never fed properly…we still think he[birthfather]'s using*<br><br>*I can see what was going to happen [birthparent suicide], but I couldn't see it at the time. Or maybe I just didn't want to see "was my dad a bad man?" and I said no, he wasn't a bad man, but he made some wrong choices*<br><br>*a history of violence towards women, and he's been in that prison and*<br><br>*Dad who is our nephew is out of prison at the moment. He lives in the area somewhere, but I don't know where. We've had no sign of his mom since he was 5 months old, she tried to abduct him* | Laura<br><br>Emily & Rebecca<br><br>Sarah<br><br>Steve & Terry<br><br>Clara |
| **The challenge of caring in adversity** | Familial sacrifice as the solution | *we would never have let him go into care…we say what option have we got? We wouldn't let them go back to the parents. as* | Laura |

| | | | |
|---|---|---|---|
| | | *far as I'm concerned the children come first no matter what* | |
| | | *I would not have let them go outside the family.*<br>*I'd rather be with the kids and know they're safe.* | Emily & Rebecca |
| | | *We just come to the conclusion in a funny way that anything we do now if the kids are having a good time. Means that we generally are having a very good time, …Yeah, it's hard work for us, but the kids enjoy it.* | Steve & Terry |
| | | <u>Caring is not as expected</u><br>*At the time I was quite pleased. Because we just want to give them a better life. You know, than what he probably would have had. I was quite happy, my partner was happy about it. I think it all changed for me coming out of the job. …. 'Oh, what have we done to deserve this?' We try to get on with it.* | Clara |
| | | *huge, huge impact and it didn't go how I imagined it would go.*<br>*I thought we'd be a little team, you know. But no, we're opponents.* | Laura |
| | | *I thought I'd done the right thing, but did I actually do the right thing for me?* | Emily & Rebecca |
| | | <u>Loss of imagined future</u><br>*We had plans when we come out of the (job) to do up our home, to travel the world, to basically retire or semi-retire* | Clara |
| | | *my husband is 74 this year. We should really be doing nice things* | Laura |
| | Caring for children with complex needs | <u>Communication problems</u><br>*I was her Nan she didn't want me to know everything that went on* | Emily & Rebecca |
| | | *She's a completely weird child she is. She doesn't wanna chat…she sometimes, a couple of times now has shared something with me, which she doesn't really tell me anything about her previous life* | Sarah |
| | | <u>Soothing/attachment</u><br>*before she would let go of my hand, she asked where are you gonna be?... and she couldn't wait to get back to me as soon as she* | Laura |

| | | | |
|---|---|---|---|
| | | *saw me again. we've still got issues, like night-time, going to bed is a nightmare. Getting them to sleep* | |
| | | *the only way she'd go to sleep is if you laid her down in her bed and let her scream* | Steve & Terry |
| | | <u>Carer abuse</u><br>*"you're ugly", "you're old", "you're grey"*<br>*she was threatening: "I'm gonna dig a hole and bury you"*<br>*she's hitting us, she's threatening her. We need to, you know, phone MASH. Someone needs to come and get her sort of thing. 'cause this is getting, this is dangerous* | Emily & Rebecca |
| | | *he [child] was really violent and horrible. Lots of anger issues.*<br>*the birth mother is our daughter, …in her teenage years …she used to beat me up* | Laura |
| | | <u>Behaviour that challenges</u><br>*I didn't feel in control, I was being controlled by this child, in fact we all were*<br>*He doesn't know how to cope with his emotions.*<br>*sometimes you just cannot be you cannot be one step ahead of him, he is always doing what he wants to do…it can be quite horrific* | Clara |
| | | *so her memories are bad, but obviously they're scary ones, she doesn't actually know the full extent of the danger they were* | Laura |
| | | *when she came home, she was just screaming …and crying and she was just absolutely beside herself and we couldn't settle her…* | Steve & Terry |
| | | *My life was a nightmare with her. Really, her behaviour is horrible and I didn't understand why*<br>*Quite a lot of pretending she's got an injury or an illness or a condition*<br>*She's concerned that she's going to be bad because he might have been bad* | Sarah |

| **Superordinate themes** | **Subordinate themes** | **Key Messages & Quotes** | **Participant** |
|---|---|---|---|
| Impact on carer wellbeing and need for support themselves | No time to rest, no time for basic needs | <u>No time for self and need for respite</u> | Steve & Terry |

| | | | |
|---|---|---|---|
| | | *I would say we don't have any time really to ourselves. I haven't done anything for two years.* | Emily & Rebecca |
| | | *we just feel there's no rest.* | Steve & Terry |
| | | <u>Work</u><br>*I think it's going to have an impact on work …I'm gonna request them to cut my hours* | Emily & Rebecca |
| | | *I had to give up work* | Sarah |
| | | *I had to give up work* | Clara |
| | | *"I actually went back to work July 2017* | Laura |
| | | *it hasn't impacted, I'm still doing it.* | |
| | Reduced access to social networks and intimate relationships (love and belonging) | <u>Romantic</u> | |
| | | *we have a really strong relationship* | Steve & Terry |
| | | *what we miss, what me and hubby miss, we used to just like having a long weekend here and there down by the coast or something, but that's not easy to do now* | Laura |
| | | <u>Social</u> | |
| | | *although I can get on with anyone, I could not connect with anyone that had children even the same age as mine because it was such a vast age difference between me and them…all my friends were working and doing their own thing*<br>*"It's the day-to-day kind of socialising, the light and fun that maybe that's what's missing."*<br>*I've gone from being part of a community to being in a house.*<br>*I do have friends, I speak to my mom as well. I have got a friend that I normally talk to, she's going through a bit of a bad patch.* | Clara |
| | | *I could if somebody said, "do you wanna come out?" I could, and now I really can't. I've gotta try and find somebody to, not baby sit, but sit with her*<br>*I haven't got one [social life]*<br>*I just want to tell somebody. You know? So no, I don't, don't really have anybody.* | Sarah |
| | | *sometimes people ask us to go out and we think if we take all of these kids, it's just* | Steve & Terry |

| | | | |
|---|---|---|---|
| | | *gonna be a nightmare* | |
| | | *he's not actually got any friends as such. He's friends are my friends. So a couple of times he said I've got nobody to go and talk to. And so yeah, I think sometimes he wishes there was an avenue where he could go and let off his worries to somebody rather than trying to let me deal with that….. We don't really go out anymore* | Laura |
| | | *you had to give your social life up as well. But that's all, the job and the social* | Emily & Rebecca |
| | Emotional burden and mental health needs (well-being and self-esteem) | <u>Mental health</u> | |
| | | *I was to the stage where I sometimes sort of went to bed and think "maybe I won't wake up tomorrow and it'll be alright… I didn't wanna carry on* | Emily & Rebecca |
| | | *I don't really wanna talk about stuff that's emotional, you know, ever. … so I wouldn't seek that support."* | Sarah |
| | | *I've had a couple of days where I've just thought I just wanna sit and cry…*<br>*it was really tough when we first took him on* | Laura |
| | | *Hubby struggles more… he did access talking therapy…I've never sort of had depression like that until… I felt lost* | Clara |
| | | *it's had an emotional impact in terms of me I suppose the breaking off of the relationship with their mum.* | Steve & Terry |
| | | <u>Mental health support</u> | |
| | | *he wishes there was an avenue where he could go and let off his worries to somebody rather than trying to let me deal with that.* | Laura |
| | | *could probably say that for the mental health issues are, I don't really know what they have in place… Maybe, being able to talk more with them about the mental health side of things and being able to cope. That's it really because, you know, they have been* | Clara |
| | | *they [GP] offered me tablets first. But I have never been offered someone to talk to* | Sarah |

| | | | |
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| | | | |

## Appendix N – SIP: Additional Recommendations

**Table 4.** *Additional recommendations to take forward to commissioning body per superordinate theme*

| Recommendations | Rationale |
|---|---|
| **Navigating services and help-seeking** | |
| Information for, and communication with, carers including leaflets about the role and its implications. | Easily available and accessible online, and due to carers being older also in print in GPs, schools and social care. |
| Earlier involvement of services including a map of access to them | Support services should be identified during the initial SGO assessment. Later access to support services should be easy to find, include a complete review of needs leading to access to a range of services. It should also be at a time and place that fit family schedules (e.g. school). |
| Preparation for SGO including:<br>• funding for legal advice or one off sessions<br>• briefing carers during the assessment phase<br>• signposting to other agencies such as Family Rights Group and Grand Parents Plus | Carers explained that they were unsure that the SGO was the right choice for them and felt unprepared and ill informed.<br>More support before the SGO could help carers decide on the right option for them. |
| Developing partnerships and systems to better integrate support from health, safeguarding, CAMHS, ATTACH and social care (e.g. a social care advocate like a mental health advocate).<br>Improve cooperation and communication within local authority services and between agencies to provide more coordinated support to carers. | Carers have lamented the disjointedness of systems. They felt it was hard and slow to get the right help, for their child/ren – who often had complex needs. In the meantime, carers and their families bridged the gap to ensure placement stability and child well-being often at their own expense. Better integration could reduce the burden on carers and their busy schedule. |
| **Negotiating new family structure and relationships** | |
| Preparation for carers: psychoeducation packs and workshops run throughout the year | Psychoeducation about how to manage the transition could be offered by social workers as part of a start up pack following granting of the SGO by the courts. Due to their didactic nature, workshops could be run by social care. |
| Community support group | As in the above table, carers expressed a desire for peer support, social care could help to link carers with community groups. |
| **The challenge of caring in adversity** | |

| | |
|---|---|
| Dissemination of materials and training about challenges of transition, new structure and attachment.<br>For example: preplacement training, a dedicated website, a welcome pack, a support booklet for carers | Carers described the realities of caring to differ considerably from their expectations and valued reassurance. Better information could help to and normalising their experience and make them feel better prepared. |
| Help managing contacts including:<br>• training for carers<br>• templates for contact with guidance notes<br>• Mediation training for social workers<br>• point of contact for carers to get temporary mediation and assistance<br>• letter box contact<br>• contact review meetings<br>• written contact agreements setting out expectations and arrangements<br>• time limited contact supervision | Carers reported difficulties managing contacts and expressed a desire for more support. Shared parental responsibility can be challenging.<br>. |
| **Impact on carer wellbeing and need for support themselves** | |
| Respite care | The busyness and demands of the caring role, paired with carers concerns about finding appropriate individuals to look after the child/ren in light of their complex needs meant they got little time to themselves. This impacted on their ability to have time for their relationships romantic or otherwise, and a feeling of exhaustion particularly for older carers. Many of them mentioned a desire for respite to get some rest and felt this should have been offered. Time for self-care would help carers increase their well-being and resilience. |

**Appendix O – TDRP: Recruitment materials**

Digital flyers stating the anonymous and online nature of the survey, the aims of the study, the ethics reference, organisation details, and with links to the survey and the department's online research page.

Sensitivity to betrayal and new intimate relationship building in survivors of intimate partner violence

The Oxford Institute of Clinical Psychology Training and Research

University of Oxford, Isis Education Centre, Warneford Hospital, Oxford, OX3 7JX

Researchers: Alice Melin (Trainee Clinical Psychologist; alice.melin@hmc.ox.ac.uk), Professor Paul Salkovskis (Principal Investigator & Director, Oxford Centre for Psychological Health; paul.salkovskis@hmc.ox.ac.uk)

Central University Research Ethics Approval (University of Oxford) Reference: R78380/RE001

Researchers from the University of Oxford want to hear from you.

Have you found love following an abusive and violent relationship?

Whether you have found love, are still looking or have decided to remain single after surviving intimate partner violence we would like to hear from you.

Can you help us? We are researchers from the Oxford Institute of Clinical Psychology at The University of Oxford, and we are interested to understand the barriers that women face when seeking to build new relationships with men after their abuse. This research is restricted to women because it is informed by previous publications that consider intimate partner violence within the framework of gender-based violence or violence against women.

Please note that for research purposes we are ALSO recruiting women who have NOT experienced intimate partner violence.

Please consider taking part in this study to help us understand how survivors build new romantic relationships.

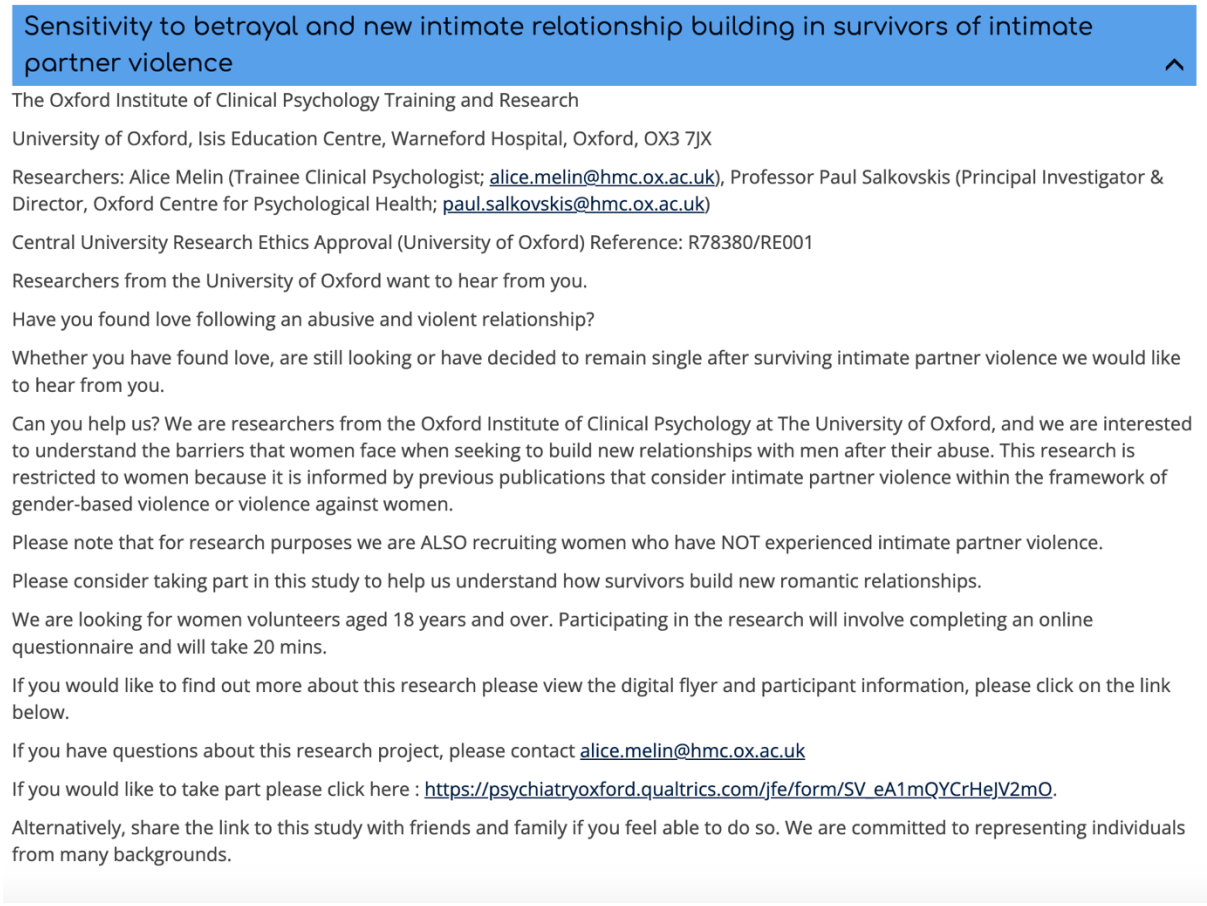
We are looking for women volunteers aged 18 years and over. Participating in the research will involve completing an online questionnaire and will take 20 mins.

If you would like to find out more about this research please view the digital flyer and participant information, please click on the link below.

If you have questions about this research project, please contact alice.melin@hmc.ox.ac.uk

If you would like to take part please click here: https://psychiatryoxford.qualtrics.com/jfe/form/SV_eA1mQYCrHeJV2mO.

Alternatively, share the link to this study with friends and family if you feel able to do so. We are committed to representing individuals from many backgrounds.



## Sensitivity to betrayal and new intimate relationship building in survivors of intimate partner violence

The Oxford Institute of Clinical Psychology Training and Research

University of Oxford, Isis Education Centre, Warneford Hospital, Oxford, OX3 7JX

Researchers: Alice Melin (Trainee Clinical Psychologist; alice.melin@hmc.ox.ac.uk), Professor Paul Salkovskis (Principal Investigator & Director, Oxford Centre for Psychological Health; paul.salkovskis@hmc.ox.ac.uk)

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Please consider taking part in this study to help us understand how survivors build new romantic relationships.

We are looking for women volunteers aged 18 years and over. Participating in the research will involve completing an online questionnaire and will take 20 mins.

If you would like to find out more about this research please view the digital flyer and participant information, please click on the link below.

If you have questions about this research project, please contact alice.melin@hmc.ox.ac.uk

If you would like to take part please click here : https://psychiatryoxford.qualtrics.com/jfe/form/SV_eA1mQYCrHeJV2mO.

Alternatively, share the link to this study with friends and family if you feel able to do so. We are committed to representing individuals from many backgrounds.

https://oxicptr.web.ox.ac.uk/help-our-research#collapse3384606


UNIVERSITY OF
OXFORD
ARE YOU A WOMAN WHO HAS EXPERIENCED INTIMATE PARTNER ABUSE IN THE PAST?
I am conducting research at the University of Oxford to understand the barriers that women face when seeking to build new relationships after their abuse.
I am currently recruiting women who have experienced intimate partner violence in the past. You will be asked to complete a one off, anonymous online survey.
For more information or to take part please scan the QR code on the next page
Ethics reference: R78380/RE001

**Appendix P – TDRP: Participant Information Page and consent**

Intro
**(Ethics ID: R78380/RE001)**

**Title: Sensitivity to betrayal and new intimate relationship building in survivors of intimate partner violence (IPV)**

Before agreeing to take part in this research study, please read the below information to ensure you understand why the research is being carried out, and what it would involve for you. If you have any questions about the research, or would like further information please contact Alice Melin at alice.melin@hmc.ox.ac.uk.

**What is the purpose of the research?**

We do not know much about the relationship difficulties people who have experienced IPV (here called survivors) develop following their abuse and how it might change their ability to trust new partners. Betrayal is when someone you trust does something on purpose that causes you emotional harm.

In this project, we want to look at levels of sensitivity to betrayal among women who have experienced intimate partner violence (IPV) from a male partner. We will do this by comparing two groups: those who are in happy relationships with those who are not, either because they are single or because they are in unhappy relationships. These groups will be compared to an additional one made up of participants who have not experienced IPV but are in a happy relationship.

**Can I take part in the research?**

We are aiming to recruit a minimum of 80 women who have in the past been subjected to intimate partner violence from a man. They cannot be currently in an abusive relationship and must have been separated from their abuser for a minimum of one year.
Within this group, we are looking to recruit a minimum of 40 women who are currently in a relationship with which they are satisfied, as well as a minimum 40 women who are either in unhappy relationships or single.

Finally, we are also looking to recruit a minimum of 40 women who have never been in an abusive relationship and are in a satisfied relationship.

By 'Intimate partner violence (IPV)' we mean "behaviour within an intimate relationship that causes physical or sexual harm".

This includes:

- acts of physical aggression

- sexual coercion

Perpetrated by men towards their intimate partners who are women

All women wishing to take part must also be at least 18 years old and able to read and write in English. They must NOT be currently in an abusive or violent intimate relationship and need to have been separated from their previous abuser for at least a year. Women with a history of a serious mental illness such as schizophrenia or bipolar disorder are not eligible to take part in this research.

Recruitment will close when three groups detailed above have reached a minimum of 40 women per group or when the period of recruitment has ended.

**What will happen if I decide to take part?**

Your participation in this study is entirely voluntary. If you decide to take part in the research you will be invited to complete the online survey at the end of this information sheet. We expect that this will take approximately 30-45 minutes to complete. The survey is completed anonymously, you will not be asked to provide your name or location.

The survey asks you to complete questionnaires which include questions about:

Your background, such as your age and ethnicity
Your experience of intimate partner violence
Your relationship satisfaction if you are in a relationship
Your sensitivity to betrayal
Your feelings of shame
Your feelings of self-criticism

If you are in the group of women who have not experienced IPV you will not be asked to complete a questionnaire on IPV. If you are single, you will not be asked to answer questions about relationship satisfaction.

**Are there any possible risks or disadvantages from taking part?**

You will be asked about how you feel and some brief details about your experiences. It is possible that some people may find this difficult or upsetting. If you would find answering these questions too upsetting or difficult, you should not enrol in the study. You do not have to answer any questions that you don't want to, and you are free to take a break, or stop completing the survey at any point. At the end of the survey you will be directed to information and contact details of potential sources of support. If you would like to seek support before, during or on completion of the survey, you may wish to contact your GP, the NHS 111 helpline or the Samaritans by calling 116 123. If you would like specific support around your experience of intimate partner violence, you may wish to contact the National Centre for Domestic Violence on 0800 970 2070 or the National Domestic Violence Helpline, which is open (24/7) on 0808 2000 247.

**Are there any benefits of taking part?**

There are no individual benefits from taking part in this study. It is hoped that this research will have a beneficial impact on understanding how to better support women survivors of intimate partner violence to build and maintain new intimate relationships following their traumatic experiences.

**Are there any expenses or payments available?**

Since this is an online anonymous survey, there will be no payments for participation in this research.

**Who is organising the study?**

The study is being completed as part of a doctorate in Clinical Psychology which is accredited by the University of Oxford. It is being led by Alice Melin, who is supervised by Professor Paul Salkovskis, Director of The Oxford Institute of Clinical Psychology Training and Research. The funding for the project is provided by the Oxford Institute of Clinical Psychology.

**What will happen to my data?**

All information collected during the study will be kept confidential. You are not asked to provide any information that would directly identify you. Instead, all participants are allocated a participant identification number by the online survey provider. You can choose how much information to provide in the questionnaire responses. The research team will have access to your data, and this may be shared with authorised members of the University of Oxford for the purposes of monitoring and/or audit.

All data will be stored securely on a password protected file on the Oxford University Nexus 365 Secure One Drive while the study is ongoing. You can stop completion of the online questionnaire at any time, by closing the browser, and there is no obligation to complete it. Since your contributions are anonymous and not identifiable, there is no way for you to withdraw your participation once you submit the questionnaire. After recruitment ends, data will be analysed and written into the final report. After completion of the project, in line with University of Oxford regulations all data will be stored securely for three years on a password protected file on the Oxford University Nexus 365 Secure One Drive.

The data collected in this research will be published as part of a doctoral thesis which will be stored in print and online in the University archives. In addition, the data may be used in research papers published in academic journals. No identifiable information will be published.
You will be able to view a summary of the results by returning to the previous webpage (landing page address) once the report has been written and the doctoral thesis approved.

**Who has reviewed the study?**

This research has been reviewed and approved by a subcommittee of the University of Oxford Central University Research Ethics Committee (CUREC). The ethics approval number for this research is R78380/RE001.

If you have a concern about any aspect of this study, please contact Alice Melin (alice.melin@hmc.ox.ac.uk) or Professor Paul Salkovskis (paul.salkovskis@hmc.ox.ac.uk) and we will do our best to answer your query. We will acknowledge your concern within 10 working days and give you an indication of how it will be dealt with.

If you remain unhappy, or wish to make a formal complaint, please contact the Chair of the Medical Sciences Interdivisional Research Ethics Committee at the University of Oxford: Email: ethics@medsci.ox.ac.uk; Address: Research Services, University of Oxford, Boundary Brook House, Churchill Drive, Headington, OX3 7GB.

**Informed consent**

Please tick to confirm the following:

☐ I confirm that I have read and understand the information on previous page dated (15.12.2021) for this study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. (1)

☐ I understand that my participation is voluntary and that there is no obligation for me to complete this online questionnaire and I can change my mind about participation in the research at any point before I complete it. I also understand that since this questionnaire is anonymous I will not be able to withdraw my data once submitted. (2)

☐ I understand that research data collected during the study may be looked at by authorised people outside the research team. I give permission for these individuals to access my data. (3)

☐ I understand who will have access to the data provided, how the data will be stored and what will happen to the data at the end of the project. (4)

☐ I understand that all information will be kept strictly confidential. (5)

☐ I understand how this research will be written up and published. (6)

☐ I understand how to raise a concern or make a complaint. (7)

☐ I understand that this project has been reviewed by, and received ethics clearance through, the University of Oxford Central University Research Ethics Committee. (8)

☐ I agree to take part in the study (9)

☐ I have read and understood the above information and agree to take part in this study (10)

---

Or please tick the below if you do not wish to take part in this study

☐ I do not wish to take part in the study at this time (1)

I am eligible to take part in this study as I can confirm that I:

- ☐ Identify as a woman / am a woman (1)
- ☐ Am aged 18 years or older (2)
- ☐ Can read and write in English (3)
- ☐ Do not have a diagnosis of a serious mental illness such as psychosis, schizophrenia or bipolar disorder (4)

Please tick as appropriate:

- ○ I can confirm that I meet the above criteria and would like to take part in the research (1)
- ○ I do not meet the above criteria and therefore am unable to take part in the research (2)

## Debrief

**Sensitivity to Betrayal and New Intimate Relationship Building in Survivors of Intimate Partner Violence**
(Ethics ID: R78380/RE001)

Thank you for taking part in this study, we really appreciate your help!
In this project we want to look at levels of sensitivity to betrayal among women who have experienced intimate partner violence (IPV) to find out why it can be harder for those that have experienced DV and therefore a betrayal of trust from their partner, to form new intimate relationships. Your responses to the questionnaires will help us to answer the above question.
If you know any survivors of IPV who may like to participate in this study, you are welcome to provide them with the link to this questionnaire:
https://psychiatryoxford.qualtrics.com/jfe/form/SV_eA1mQYCrHeJV2mO

Please note that for research purposes we are ALSO recruiting women who have NOT experienced intimate partner violence. Please share the link to this study with friends and family if you feel able to do so. We are committed to representing individuals from many backgrounds.

If you are a survivor of IPV you may feel upset or distressed by any of the questions in the survey. If this is the case or if feel you could benefit from seeking mental health support, please find below details for support services: Your General Practitioner (GP) Improving Access to Psychological Therapies. Free NHS therapy for low mood or anxiety. You can be referred via your GP or by completing a self-referral form online here https://www.nhs.uk/service-search/find-a-psychological-therapies-service/. Calling NHS 111 helpline. The Samaritans. Free to call at any time for support with low mood or thoughts of suicide at 116 123. **If you are experiencing a mental health crisis, please call 999 or attend your local A&E.** If you are a survivor of IPV and feel upset or distressed following completion of this survey. Please consider completing the below exercise if you feel distressed.

### Grounding techniques

When reflecting on difficult past experiences, it is normal to experience uncomfortable feelings such as anxiety and other symptoms including flashbacks. Grounding techniques help manage these symptoms by turning attention away from thoughts, memories, or worries, and refocusing on the present moment.

### 5-4-3-2-1 technique

You will purposefully take in the details of your surroundings using each of your senses. Strive to notice small details that your mind would usually tune out, such as distant sounds, or the texture of an ordinary object. What are **5** things you can **see**? Look for small details such as a pattern on the ceiling, the way light reflects off a surface or an object you never noticed. What are **4** things you can **feel**? Notice the sensation of clothing on your body, the sun on your skin, or the feeling of the chair you are sitting in. Pick up an object and examine its weight, texture, and other physical qualities. What are **3** things you can **hear**? Pay special attention to the sounds your mind has tuned out, such as ticking clock, distant traffic,

or trees blowing in the wind. What are **2** things you can **smell**? Try to notice smells in the air around you, like an air freshener or freshly mowed grass. You may also look around for something that has a scent, such as a flower or an unlit candle. What is **1** thing you can **taste**? Carry gum, candy, or small snacks for this step. Pop one in your mouth and focus attention closely on the flavours.

For more specific support regarding intimate partner violence, please contact any of the below charities:

National Centre for Domestic Violence Provides a free, fast emergency injunction service to survivors of domestic violence to prevent them from being further abused. Tel: 0800 970 2070 Text: NCDV to 60777 Website: www.ncdv.org.uk/ Women can call The Freephone National Domestic Abuse Helpline, run by Refuge on 0808 2000 247 for free at any time, day or night. The staff will offer confidential, non-judgemental information and support.

Refuge. Refuge provides emergency accommodation and advice for women and children dealing with domestic violence. Their staff speak 44 languages and Refuge provides culturally specific services for Eastern European, Vietnamese, African, Caribbean and Asian women. Helpline (National Domestic Violence Helpline): 0808 2000 247 (24/7) Website: www.refuge.org.uk Women can email helpline@womensaid.org.uk. Staff will respond to your email within 5 working days.

To remind you, all data will be stored securely on a password-protected file on the Oxford University Nexus 365 Secure One Drive while the study is ongoing.

You can stop completion of the online questionnaire at any time, by closing the browser, and there is no obligation to complete it. Since your contributions are anonymous and not identifiable, there is no way for you to withdraw your participation once you submit the questionnaire. After recruitment ends, data will be analysed and written into the final report. After completion of the project, in line with University of Oxford regulations, all data will be stored securely for three years on a password-protected file on the Oxford University Nexus 365 Secure One Drive.

The data collected in this research will be published as part of a doctoral thesis which will be stored in print and online in the University archives. In addition, the data may be used in research papers published in academic journals. No identifiable information will be published.

You will be able to view a summary of the results by returning to the previous webpage https://oxicptr.web.ox.ac.uk/help-our-research once the report has been written and the doctoral thesis approved.

If you have any more questions about any aspect of this project, please speak to the researcher Alice Melin (alice.melin@hmc.ox.ac.uk) or her supervisor Professor Paul Salkovskis (paul.salkovskis@hmc.ox.ac.uk), and we will do our best to answer your query

If you have any more questions about any aspect of this project, please speak to the researcher Alice Melin (alice.melin@hmc.ox.ac.uk) or her supervisor Professor Paul Salkovskis (paul.salkovskis@hmc.ox.ac.uk), and we will do our best to answer your query. If you have any concerns, or wish to make a formal complaint, please contact the

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

Chair of the Medical Sciences Interdivisional Research Ethics Committee at the University of Oxford:
Email: ethics@medsci.ox.ac.uk; Address: Research Services, University of Oxford, Boundary Brook House, Churchill Drive, Headington, OX3 7GB.

Please press next to submit your responses

## Appendix Q – TDRP: Descriptive characteristics

Table 2. *Demographic characteristics of groups*

| | IPV single group *n*= 34 N (%) | IPV dissatisfied *n*= 25 N (%) | IPV satisfied *n*=32 N (%) | Non-clinical Group *n*= 42 N (%) | IPV *n*= 7 N (%) |
|---|---|---|---|---|---|
| **Age** | | | | | |
| 18 - 25 years | 1 (2.9%) | 1 (4.0%) | 5 (15.6%) | 4 (9.5%) | 1 (2.9%) |
| 26 - 35 years | 8 (23.5%) | 2 (8.0%) | 11 (34.4%) | 22 (52.4%) | 8 (23.5%) |
| 36 - 55 years | 20 (58.8%) | 18 (72.0%) | 14 (43.8%) | 14 (33.3%) | 20 (58.8%) |
| 56 years + | 5 (14.7%) | 4 (16.0%) | 1 (3.1%) | 2 (4.8%) | 5 (14.7%) |
| Prefer not to say | | | 1 (3.1%) | | |
| **Age** | | | | | |
| 18-35 | 9 (26.5%) | 3 (12%) | 16 (50%) | 26 (61.9%) | 9 (26.5%) |
| 35+ | 25 (73.5%) | 22 (88%) | 15 (48.9%) | 15 (38.1%) | 25 (73.5%) |
| Prefer not to say | | | 1 (0.03%) | | |
| **Ethnicity** | | | | | |
| White | 30 (88.2%) | 22 (88%) | 29 (90.6%) | 36 (85.7%) | 30 (88.2%) |
| Non - white | 4 (11.8%) | 3 (12%) | 3 (9.4%) | 6 (14.3%) | 4 (11.8%) |
| **Employment Status** | | | | | |
| In work or study | 29 (85.3%) | 19 (76.0%) | 29 (90.6%) | 38 (90.5%) | 29 (85.3%) |
| Not working | 5 (14.7%) | 6 (24.0%) | 3 (9.4%) | 4 (9.5%) | 5 (14.7%) |
| **Highest level of education** | | | | | |
| Academic Higher | 22 (64.7%) | 13 (52.0%) | 25 (78.1%) | 40 (95.2%) | 22 (64.7%) |
| Qualification | 12 (35.3%) | 11 (44.0%) | 7 (21.9%) | 2 (4.8%) | 12 (35.3%) |
| Non-academic | | | | | |
| **Depression** | | | | | |
| Yes | 16 (47.1%) | 19 (76%) | 19 (59.4%) | 8 (19%) | 16 (47.1%) |
| No | 18 (52.9%) | 6 (24%) | 13 (40.6%) | 34 (81%) | 18 (52.9%) |
| **Anxiety** | | | | | |
| **Yes** | 19 (55.9%) | 14 (56%) | 21 (65.6%) | 14 (33.3%) | 19 (55.9%) |
| **No** | 15 (44.1%) | 11 (44%) | 11 (34.4%) | 28 (66.7%) | 15 (44.1%) |
| **PTSD** | | | | | |
| **Yes** | 15 (44.1%) | 15 (60%) | 12 (37.5%) | 2 (4.8%) | 15 (44.1%) |
| **No** | 19 (55.9%) | 10 (40%) | 20 (62.5%) | 40 (95.2%) | 19 (55.9%) |

| | | | | | |
|---|---|---|---|---|---|
| **Relationship Status** | | | | | |
| **In a relationship** | | 25 | 32 | 40 | 7 |
| **Single** | 34 | | | 2 | |

† does not include the participants who were removed for the IPV Satisfied and Dissatisfied group

**Appendix R – TDRP: Measures and additional questions**

Additional questions focused on previous mental health difficulties, support and trauma history.

**Dyadic Adjustment Scale (DAS-7): Current relationship satisfaction**

Most persons have disagreements in their relationships. Please indicate below the approximate extent of agreement or disagreement between you and your CURRENT partner for each item on the following list.

| | **Always agree** | **Almost Always Agree** | **Occasionally Disagree** | **Frequently disagree** | **Almost Always Disagree** | **Always Disagree** |
|---|---|---|---|---|---|---|
| Philosophy of life | ○ | ○ | ○ | ○ | ○ | ○ |
| Aims, goals, and things believed important | ○ | ○ | ○ | ○ | ○ | ○ |
| Amount of time spent together (agree or disagree on how much time to spend together) | ○ | ○ | ○ | ○ | ○ | ○ |

**How often would you say the following events occur between you and your mate/boyfriend/partner?**

| | **Never** | **Less than once a month** | **Less than twice a month** | **Once or twice a week** | **Once a day** | **More often** |
|---|---|---|---|---|---|---|
| Have a stimulating exchange of ideas | ○ | ○ | ○ | ○ | ○ | ○ |
| Calmly discuss something together | ○ | ○ | ○ | ○ | ○ | ○ |
| Work together on a project | ○ | ○ | ○ | ○ | ○ | ○ |

**DAS-7**

**The dots on the following line represent different degrees of happiness in your relationship. The middle point, "happy", represents the degree of happiness of most relationships. Please place the slider on the line that best describes the degree of happiness, all things considered, of your relationship.**

| | Extremely unhappy | Fairly unhappy | A little unhappy | Happy | Very happy | Extremely happy | Perfect |
|---|---|---|---|---|---|---|---|
| | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| **Degrees of happiness** () |  | | | | | | |

Experiences of IPV **In the previous relationship that was abusive, did you experience any of the below? Please tick all that apply:**

- ☐ My former partner shouted at me or used abusive language (1)
- ☐ My former partner pushed or slapped me intentionally (2)
- ☐ My former partner kicked or punched me intentionally (3)
- ☐ My former partner destroyed my belongings intentionally (4)
- ☐ My former partner used threats and intimidation (5)
- ☐ I sustained physical injuries following an argument or fight with my former partner (6)
- ☐ My injuries following an argument or fight with my former partner were so severe I had to seek medical attention (7)
- ☐ My former partner forced me into having sexual relations (8)
- ☐ My former partner posted unwanted photos and videos of a sexual nature on the internet (9)

**Perception of Betrayal Scale (POBS)**
**Supplementary data: Perception of Betrayal Scale, showing 27 items retained, 15 excluded following factor analysis.**

**POBS**

The questions below ask you to think about times when you have experienced betrayal. **Betrayal is when someone you trust does something on purpose that causes you emotional harm.**

The most common forms of betrayal are given below, with an example of each kind of betrayal.

| | |
|---|---|
| • Disloyalty | For example, if a close friend is cruel or laughs about you to others behind your back |
| • Infidelity | For example, if a partner has an affair with someone else |
| • Dishonesty or deception | For example, if a close friends lies to you about something important |
| • Disclosing confidential information | For example, if a close friend tells other people things you have asked them to keep secret |
| • Sexually inappropriate behaviour | For example, if a trusted friend makes 'a pass' at you when you are feeling vulnerable |
| • Failing to help you when you need help | For example, if you have been falsely accused of a crime and your friend fails to help you even though they could. |

**Please circle how much you agree with the statements below, when thinking about yourself and how your experiences have had an impact on you.**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 1 (F1) | My thoughts are often preoccupied with past betrayals | **Strongly disagree** | **Disagree** | **Disagree a little** | **Neither agree or disagree** | **Agree a little** | **Agree** | **Strongly agree** |
| 2 (F2) | My experience of betrayal has changed the way I think about the world in general | **Strongly disagree** | **Disagree** | **Disagree a little** | **Neither agree or disagree** | **Agree a little** | **Agree** | **Strongly agree** |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 3<br>(F3) | I know that I have to rely on myself in a crisis because other people will let me down | **Strongly disagree** | **Disagree** | **Disagree a little** | **Neither agree or disagree** | **Agree a little** | **Agree** | **Strongly agree** |
| 4<br>(F1) | When thoughts or memories of past betrayals come to mind, I turn then over and over in my head | **Strongly disagree** | **Disagree** | **Disagree a little** | **Neither agree or disagree** | **Agree a little** | **Agree** | **Strongly agree** |
| 5<br>(F2) | My experience of betrayal has changed how I think about myself | **Strongly disagree** | **Disagree** | **Disagree a little** | **Neither agree or disagree** | **Agree a little** | **Agree** | **Strongly agree** |
| 6<br>(F3) | I am careful about getting close to people for fear they will let me down | **Strongly disagree** | **Disagree** | **Disagree a little** | **Neither agree or disagree** | **Agree a little** | **Agree** | **Strongly agree** |
| 7<br>(F4) | When I think about my experiences of betrayal, I still feel shocked that this happened to me | **Strongly disagree** | **Disagree** | **Disagree a little** | **Neither agree or disagree** | **Agree a little** | **Agree** | **Strongly agree** |
| 8<br>(F3) | I worry more than other people about how likely it is that people will betray my trust | **Strongly disagree** | **Disagree** | **Disagree a little** | **Neither agree or disagree** | **Agree a little** | **Agree** | **Strongly agree** |
| 9<br>(F1) | Thoughts or memories of past betrayals often come to my mind out of nowhere | **Strongly disagree** | **Disagree** | **Disagree a little** | **Neither agree or disagree** | **Agree a little** | **Agree** | **Strongly agree** |
| 10<br>(F1) | When I am reminded of past betrayals, I feel the urge to do something in response | **Strongly disagree** | **Disagree** | **Disagree a little** | **Neither agree or disagree** | **Agree a little** | **Agree** | **Strongly agree** |
| 11<br>(F3) | It's best not to rely on others as you never know when they're going to let you down | **Strongly disagree** | **Disagree** | **Disagree a little** | **Neither agree or disagree** | **Agree a little** | **Agree** | **Strongly agree** |
| 12<br>(F3) | My experience of past betrayals interferes with my ability to form close relationships | **Strongly disagree** | **Disagree** | **Disagree a little** | **Neither agree or disagree** | **Agree a little** | **Agree** | **Strongly agree** |
| 13<br>(F1) | Images or pictures of past betrayals often come to my mind out of nowhere | **Strongly disagree** | **Disagree** | **Disagree a little** | **Neither agree or disagree** | **Agree a little** | **Agree** | **Strongly agree** |
| 14<br>F(1) | When I think about past betrayals, I feel tainted | **Strongly disagree** | **Disagree** | **Disagree a little** | **Neither agree or disagree** | **Agree a little** | **Agree** | **Strongly agree** |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 15<br>(F1) | I find myself thinking about past acts of betrayal more than I should | **Strongly disagree** | **Disagree** | **Disagree a little** | **Neither agree or disagree** | **Agree a little** | **Agree** | **Strongly agree** |
| 16<br>(F2) | The choices I make about my life have changed as a result of betrayals I have experienced | **Strongly disagree** | **Disagree** | **Disagree a little** | **Neither agree or disagree** | **Agree a little** | **Agree** | **Strongly agree** |
| 17<br>(F2) | My experience of betrayal has changed how I think about people | **Strongly disagree** | **Disagree** | **Disagree a little** | **Neither agree or disagree** | **Agree a little** | **Agree** | **Strongly agree** |
| 18<br>(F1) | When I think of past betrayals I feel distressed | **Strongly disagree** | **Disagree** | **Disagree a little** | **Neither agree or disagree** | **Agree a little** | **Agree** | **Strongly agree** |
| 19<br>(F2) | My experience of betrayal has changed how I react to other people | **Strongly disagree** | **Disagree** | **Disagree a little** | **Neither agree or disagree** | **Agree a little** | **Agree** | **Strongly agree** |
| 20<br>(F2) | My experience of betrayal has affected my judgement | **Strongly disagree** | **Disagree** | **Disagree a little** | **Neither agree or disagree** | **Agree a little** | **Agree** | **Strongly agree** |
| 21<br>(F3) | My experience of betrayal has reduced my ability to trust other people | **Strongly disagree** | **Disagree** | **Disagree a little** | **Neither agree or disagree** | **Agree a little** | **Agree** | **Strongly agree** |
| 22<br>(F2) | My experience of betrayals has changed how others see me | **Strongly disagree** | **Disagree** | **Disagree a little** | **Neither agree or disagree** | **Agree a little** | **Agree** | **Strongly agree** |
| 23<br>(F1) | I spend a lot of time trying to understand why the betrayal happened to me | **Strongly disagree** | **Disagree** | **Disagree a little** | **Neither agree or disagree** | **Agree a little** | **Agree** | **Strongly agree** |
| 24<br>(F1) | I frequently find myself thinking about past betrayals | **Strongly disagree** | **Disagree** | **Disagree a little** | **Neither agree or disagree** | **Agree a little** | **Agree** | **Strongly agree** |
| 25<br>(F4) | I often think about punishing the person / people who have betrayed me | **Strongly disagree** | **Disagree** | **Disagree a little** | **Neither agree or disagree** | **Agree a little** | **Agree** | **Strongly agree** |
| 26<br>(F4) | When I think about my experiences of betrayal, I feel very angry | **Strongly disagree** | **Disagree** | **Disagree a little** | **Neither agree or disagree** | **Agree a little** | **Agree** | **Strongly agree** |
| 27<br>(F4) | When I think about my experiences of betrayal, I still find it hard to believe it really happened. | **Strongly disagree** | **Disagree** | **Disagree a little** | **Neither agree or disagree** | **Agree a little** | **Agree** | **Strongly agree** |

***Note.*** **F# denotes which factor (subscale) the item is included in: F1=Preoccupation with betrayal events; F2=Betrayal causing life change; F3=Lack of trust due to betrayal; F4=Betrayal leading to traumatic responses**

## Appendix S – TDRP Ethical Approval

Research Ethics Committee (R78380/RE001; Appendix D).

**MEDICAL SCIENCES INTERDIVISIONAL RESEARCH ETHICS COMMITTEE**
Research Services, Boundary Brook House, Churchill Drive, Headington, Oxford, OX3 7GB
Tel: +44(0)1865 616575
ethics@medsci.ox.ac.uk

**CONFIDENTIAL**

Alice Merlin
The Oxford Institute of Clinical Psychology Training & Research (OxICPT)
Isis Education Centre
Warneford Hospital
Oxford

15 December 2021

Dear Alice,

**Research Ethics Approval - CUREC 2**

**Ethics Approval Reference: R78380/RE001**

**Study title: Sensitivity to betrayal and new intimate relationship building in survivors of intimate partner violence**

**Short title: Love after betrayal in survivors of domestic violence**

The above application has been considered on behalf of the Medical Sciences Interdivisional Research Ethics Committee (MS IDREC) in accordance with the University's procedures for ethical approval of all research involving human participants.

I am pleased to inform you that, on the basis of the information provided to the IDREC, the proposed research has been judged as meeting appropriate ethical standards, and approval has been granted for a period of **18 months**, commencing on **15th December 2021.**

You will be required to submit an annual progress report on each anniversary of study approval, until the study is completed, and your study may be selected for review during an annual audit.

**Amendments**

Should there be any subsequent changes to the study, you should submit details to the MS IDREC for consideration and approval. Details of changes must be listed on an amendment form.

Yours Sincerely

H. Barnby-Porritt

Dr Helen Barnby-Porritt
Research Ethics Manager

**Appendix T – TDRP: Author Guidance**

**Journal of Child and Family Studies**

Manuscript Style

All manuscripts should follow the recommendations of the 2019 Publication Manual of the American Psychological Association (Seventh Edition). Submissions should be formatted to print out double-spaced at standard 8" x 11" paper dimensions, using a 12 pt. font size and a default typeface (recommended fonts are Times, Times New Roman, Calibri and Arial). Set all margins at one inch, and do not justify the right margin. Double-space the entire manuscript, including title page, abstract, list of references, tables, and figure captions. After the title page, number pages consecutively throughout including the reference pages, tables, and figure legends. Manuscripts should be no more than 30 pages in length, including all tables, figures, and references.

The Journal encourages the publication of research that is virtually jargon-free and easy to read. Thus, a personalized manuscript, written in active tense, is preferred. For example, "This study examined . . ." could be stated as, "We examined . . ." The Journal encourages a conversational rather than an impersonal tone in the manuscripts.

Title Page

A title page is to be provided and should follow APA-style. The title page should include the following elements: (1) the title (maximum of 15 words) (2) brief running head (50 characters or fewer) (3) full names of the authors (without degree). Use the form first name, middle initial, last name (e.g., John D. Doe) separated by a common and the word "and" before the last author (4) author affiliation addresses. Use a lower-case superscript letter immediately after the author's name and in front of the appropriate address. Provide the full postal address of each affiliation, including the country name. (5) corresponding author information. Include the corresponding author's initials and last name (without degree), affiliation, mailing address, and e-mail address.

Abstract

The abstract should follow APA-style single paragraph format and should be not more than 250 words. It should be a concise and complete summary of the contents of the manuscript, without reference to the body of the paper. Per APA guidance, abstracts should cover key aspects of the literature review, the problem or research question(s), hypotheses, methods used (including design, measures, sample), results (major findings), and implications. Do not use sub-headings and do not cite references in the abstract.

Key Words

A list of 5 key words, separated by a comma, is to be provided directly below the abstract. Key words should address essential paper elements (research topic, population, method, and/or application of results/findings), as they are used for indexing purposes.

Highlights

Highlights are mandatory for this journal. Highlights capture the key, top-line messages of your research, for example novel results or new methods that were used during the study. Highlights should be included directly below the keywords on the same page as the Abstract. Please format highlights as 3 to 5 bullet points (approximately 125 characters, including spaces, per bullet point).

Text

Text should begin on the second numbered page and follow APA style. Authors are advised to spell out all abbreviations (other than units of measure) the first time they are used. Do not use footnotes to the text. When using direct quotations from another publication, cite the page number for the quotation in the text, immediately after the quotation. When reporting statistically significant results, include the statistical test used, the value of the test statistic, degrees of freedom, and p values. In the discussion include an evaluation of implications (clinical, policy, training or otherwise). Also, discuss limitations in study design or execution that may limit interpretation of the data and generalizability of the findings.

Footnotes

No footnotes are to be used.

References Cited Within the Text

Cite references in alphabetical order within the text.

References

The accuracy of the references is the responsibility of the authors.

List references alphabetically at the end of the paper and refer to them in the text by name and year in parentheses.

The style and punctuation of the references should conform to strict APA style – illustrated by the following examples:

Journal Article:

Roelofs, J., Meesters, C., & Muris, P. (2008). Correlates of self-reported attachment (in)security in children: The role of parental romantic attachment status and rearing behaviors. *Journal of Child and Family Studies, 17*, 555-566.

Book:

McBee, L. (2008). *Mindfulness-based elder care: A CAM model for frail elders and their caregivers*. New York: Springer.

Book Chapter:

Singh, N.N., Winton, A.S.W., Singh, J., McAleavey, K., Wahler, R.G., & Sabaawi, M. (2006). Mindfulness-based caregiving and support. In J.K. Luiselli (Ed.), *Antecedent assessment and intervention: Supporting children and adults with developmental disabilities in community settings* (pp. 269-290). Baltimore, MD: Paul H. Brookes.

Tables

Tables follow the Reference section. Tables should be submitted as editable text and not as images and should follow APA style. Tables that are a single column are actually lists and should be included in the text as such. Number tables consecutively using Arabic numerals in order of appearance in the text. Cite each table in the text and note approximately where it should be placed. Type each table on a separate page with the title and legend included.

Figures

Figures follow the tables. Figures must be submitted in electronic form. Figures and illustrations (photographs, drawings, diagrams, and charts) are to be numbered in one consecutive series of Arabic numerals.