Thesis Submitted in Partial Fulfilment of the Requirements of the Degree of Doctor of Clinical Psychology (DClinPsych)

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Abstracts

Systematic Review of the Literature (SRL): The Impact of Childhood Sexual Abuse on Interpersonal Violence in Men: A Systematic Review

Aim: The current systematic review aimed to critically examine the growing body of literature proposing that there is an 'intergenerational cycle' of violence, whereby victims of abuse during childhood are posited to have a higher propensity of becoming perpetrators during adulthood. This review examined whether there is quality evidence to support a relationship between childhood sexual abuse (CSA) victimisation and interpersonal violence perpetration (sexual/physical) in adult men. *Method:* 20 studies published between 1992 and 2022, with a total of 88,585 participants, were included in this review. The quality of studies was systematically assessed to provide a weighted conclusion to the primary research question. *Results:* Overall, there was limited evidence to confidently support or reject the link between CSA and physical and/or sexual violence in adulthood for men. The current review found that whilst there were studies that found an association on a univariate and multivariate level between CSA and interpersonal violence in adult men, significant methodological issues limit the validity of conclusions made. A sizeable proportion of high-quality studies at both univariate and multivariate levels of analysis suggest mixed results or did not find a significant relationship. *Discussion:* Implications of the results on the theory of, and research on, 'intergenerational cycles' of violence, as well as the limitations of the current study, were discussed.

Service Improvement Project (SIP): Improving outreach output to aspiring psychologists from disadvantaged socio-economic backgrounds in the Oxford Institute in Clinical Psychology Training and Research (OXICPTR)

Abstract

There is increasing recognition and action in recent years to widen participation in the clinical psychology workforce. However, much of the recent efforts have focused predominantly on diversity characteristics of ethnicity and race and much less so on other equally important diversity characteristics like socioeconomic status or class. The aim of this project was to examine ways in which the Oxford Institute in Clinical Psychology Training and Research (OXICPTR) could improve its outreach output. This project was a mixed-methods study that contained three stages. In the first stage, admissions data related to socioeconomic status from the OXICPTR was compared with admissions data nationally across all Doctorate of Clinical Psychology (DClinPsy) courses. Secondly, the experiences of 275 trainee and aspiring clinical psychologists self-identifying as from a socioeconomically disadvantaged background were surveyed and thematically analysed. Findings were summarised in terms of (i) the practical and perceptual barriers they have faced in their clinical psychology journey and (ii) their perceptions of Oxford as a training course. Lastly, 32 sixth-form students from disadvantaged schools were surveyed to explore their needs to be supported towards a career in clinical psychology. Based on these findings, recommendations for the Oxford Institute in Clinical Psychology Training and Research in terms of future outreach efforts were provided.

Theoretically Driven Research Project (TDRP): Examining the relationship between gender identity, psychological processes and social anxiety in a transgender clinical sample

Aim: There is currently limited understanding of the nature and prevalence of social anxiety disorder in transgender populations. The aim of the study was to examine the prevalence of social anxiety in a transgender sample and examine whether there were any gender identity differences in various psychological processes hypothesised to correlate with social anxiety.

Method: The current study was split into two phases. In the first phase, 251 cisgender participants were compared with 161 transgender participants on the Social Phobia Inventory (SPIN). In the second phase, 120 transgender participants from the first phase completed further measures related to cognitive-behavioural and transgender minority stress-related processes hypothesised to underlie social anxiety.

Results: Compared to cisgender males, cisgender females and transgender females, transgender males were found to have elevated social anxiety scores on the SPIN. There were no differences in cognitive behavioural measures and transgender minority stress-related measures between transgender males and females. Significant associations between cognitive and behavioural processes and social anxiety levels were found. The additional contribution of minority stress measures on predicting the level of social anxiety was smaller but significant.

Discussion: Implications of these findings on the applicability of established cognitive-behavioural models on transgender experiences of social anxiety, as well as limitations of the current study, were discussed.

Critical Review of the Literature

The Impact of Childhood Sexual Abuse on Interpersonal Violence in Men: A Systematic Review

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

Word Count: 6813

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Internal Supervisor: Paul Salkovskis

External Supervisor: N/A

Proposed Journal: This report is intended for submission to Aggression and Violent Behaviour (See Appendix 1.1 for Author Guidelines). This journal has been chosen due to its focus on areas relevant to intergenerational interpersonal violence.

Abstract

Aim: The current systematic review aimed to critically examine the growing body of literature proposing that there is an 'intergenerational cycle' of violence, whereby victims of abuse during childhood are posited to have a higher propensity of becoming perpetrators during adulthood. This review examined whether there is quality evidence to support a relationship between childhood sexual abuse (CSA) victimisation and interpersonal violence perpetration (sexual/physical) in adult men. *Method:* 20 studies published between 1992 and 2022, with a total of 88,585 participants, were included in this review. Quality of studies were systematically assessed to provide a weighted conclusion to the primary research question. *Results:* Overall, there was limited evidence to confidently support or reject the link between CSA and physical and/or sexual violence in adulthood for men. The current review found that whilst there were studies that found an association on a univariate and multivariate level between CSA and interpersonal violence in adult men, significant methodological issues limit the validity of conclusions made. A sizeable proportion of high-quality studies at both univariate and multivariate levels of analysis suggest mixed results or did not find a significant relationship. *Discussion:* Implications of the results on the theory of, and research on, 'intergenerational cycles' of violence, as well as the limitations of the current study, were discussed.

Keywords: Childhood Sexual Abuse, Violence, Aggression, Men

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The Impact of Childhood Sexual Abuse on Interpersonal Violence in Men: A Systematic Review

Introduction

Childhood sexual abuse (CSA) can be broadly defined as "any completed or attempted sexual act, sexual contact, or non-contact sexual interaction with a child" (Gilbert et al., 2009). Based on a meta-analysis which included studies that defined CSA broadly (i.e. included non-contact CSA and contact CSA), it has been estimated that the mean prevalence of CSA in women was 19.7% and 7.9% for men (Pereda et al. 2009). However, prevalence rates are likely underestimated (Widom & Morris, 1997) and may vary based on different methodological and operational definitions utilised in studies. Due to it being rarer, the sequelae of CSA in men are less well understood.

Impact of CSA on men

CSA is regarded as having both specific and non-specific effects. The impact on the psychosocial adjustment of adult victims is regarded as involving a reciprocal interaction between individual characteristics and CSA and other adverse childhood experiences throughout one's development (Beitchman et al., 1992). Its potentially devastating impact on male victims was largely overlooked until the 1980s (Dhaliwal et al., 1996), and most studies continue to focus on female samples (Gilbert et al., 2009). Gender differences on the impact of CSA are still widely disputed, with some studies (Dhaliwal et al., 1996; Romano & de Luca, 2001) suggesting that women may exhibit more internalising symptoms (e.g. depression) and men more externalising symptoms (e.g. violence), some suggesting the reverse (Abajobir et al., 2017; Garnefski & Diekstra, 1997), and some arguing that differences are statistically insignificant (Gallo et al., 2018).

CSA and aggression and violence in men

The link between CSA and the perpetration of physical and sexual aggression is often framed within a social learning model (Bandura, 1977), which contends that within a pro-abuse environment, individuals may develop norms of utilising violence to address emotional or relational issues (Akers & Jennings, 2019). However, this does not fully explain the cognitive and psychological aspects of violent behaviours, and arguably only offers explanations for direct modelling (e.g. from sexually abused to sexual abuser) but not how or why exposure to CSA may 'cross over' to physical aggression and violence.

Walker & Bright (2009) proposed a cognitive model of violence which emphasised sensitivity to humiliation and low self-esteem (LSE). They suggested that maladaptive core beliefs of LSE as a result of chronic childhood victimisation may increase one's sensitivity to humiliation. Importantly, LSE may present as "machismo", a strong or aggressive form of masculine pride which may increase one's propensity towards aggression and violence. They suggested that this form of "falsely inflated self-esteem" may explain how an individual may appear to perceive themselves positively, but due to underlying fragility of self-esteem, may feel easily humiliated due to their inability to integrate the "inevitable rejections and humiliations which even the most fortunate people cannot avoid" (Gilligan, 1996), p. 47). Sexual abuse often symbolises submission, powerlessness, and a violation of societal masculine expectations of self-sufficiency and dominance (Dhaliwal et al., 1996). This, alongside the lingering stigma of homosexuality in society (Romano & de Luca, 2001), may perpetuate a deep sense of shame, humiliation and concern for one's masculinity (Kia-Keating et al., 2005). Therefore, violence was proposed as a socially sanctioned, masculine way to mask high levels of, and hypersensitivity to, embarrassment, humiliation and shame (Walker, 2005). The use of violence on another is thus used to restore one's sense of dominance, pride, control and power (Salmivalli, 2001).

Intergenerational cycle of violence

The idea of an intergenerational ‘cycle of violence’ (e.g. Ehrensaft et al., 2003; Widom, 1989) posits that individuals who were victims of violence in their early life may have an increased chance of becoming a perpetrator of violence in adulthood. However, it is unclear how the pathways and patterns of the ‘cycle of violence’ apply to victims of CSA, for example in terms of whether it only affects certain demographics and whether it pertains to specific types of violence perpetration.

The evidence around whether intergenerational ‘cycles of violence’ exist, for men as well as women, is complicated. First, many have assumed that the cycle of violence perpetration pertains to men only. For example, in one study on the effects of childhood abuse, IPV perpetration was measured in men only and IPV victimisation in women only (Tomaszewska & Schuster, 2020). However, some have found that the association between CSA and violence was evident in women but not men (e.g. Harford et al., 2014). Others have challenged the notion of a ‘cycle of violence’ completely, for example in finding no association between CSA and later sexual offending (Leach et al., 2016). Secondly, some argued that the ‘cycle of violence’ may be specific to the violence type and does not ‘cross over’ to other types of violence, e.g. CSA victimisation results in an increased propensity for sexual violence perpetration only but not physical violence perpetration (e.g. Drury et al., 2019). Again, other studies found that exposure to CSA increased the odds of physically violent outcomes like violent offending (de Jong & Dennison, 2017) and therefore support the generalised effect of CSA on violence perpetration. Understanding the nature and existence of this association is further complicated by numerous methodological limitations such as the dominance of cross-sectional designs, retrospective self-reporting and not controlling for poly-victimisation factors.

Previous reviews have predominantly focused on sexual violence victimisation-perpetration cycles which include only sexual violence perpetration and exclude other forms of interpersonal violence perpetration (Jespersen et al., 2009; Plummer & Cossins, 2016; Seto & Lalumière, 2010), on child maltreatment more widely (e.g. Li et al., 2019) which conflate effects of CSA with other types of childhood abuse, or on outcomes like criminal offending or conduct disorder which often combines violent outcomes with other forms of non-violent or non-interpersonally violent outcomes (Maniglio, 2015). This means that it has been difficult to disentangle the specific pathways linking CSA and the perpetration of interpersonal violence (sexual and/or physical) in men. In light of this, the aim of this systematic review is to examine the nature and significance of the relationship between CSA and interpersonal violence perpetration (sexual and/or physical) in adulthood for men.

Research question

Is there good evidence that being a victim of CSA is associated with later interpersonal violence perpetration (physical and/or sexual) in adulthood for men?

Method

Search strategy

Systematic searches were conducted on 15th May 2022 across electronic databases and updated on 19th April 2023. Search strategies used on search engines and websites were supported by the Librarian at the Bodleian Library, University of Oxford. Searches were conducted on PsychInfo, PubMed, Web of Science, Embase and Cochrane Collaboration. A.H. (first author) hand-searched reference lists and Google Scholar for additional articles that were potentially eligible for inclusion and analysis. The review was prospectively registered in PROSPERO (code: CRD42022330311) by A.H.

Search terms relating to CSA (e.g. child* or youth or adolescen* or young or youth or teen and sexual abuse* or rape or sexual trauma* or molest*), sexual and physical violent outcomes (e.g. viol* or aggress* or offen* or rape or abus*) and men (e.g. men or male) were used (see Appendix 1.2 for full search strategy). The Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA; (Moher et al., 2009) flowchart illustrates the systematic review process (Figure 1.1). There were limitations to publications written in English and no limitations on publication date.

Study eligibility

CSA was operationalised as any attempted or completed sexual act, sexual contact or non-contact sexual interaction before the age of 18 years. Interpersonal violence was defined as any general or specific acts that directly attempt to, or result in, pain and injury to another individual, measured at or after 18 years of age. Studies of aggressive or violent internal processes (e.g. thoughts, urges, images) which did not involve a direct non-consensual contact that caused suffering or injury to another individual (e.g. emotional abuse, neglect) were not included. Therefore, outcomes related to aggression towards inanimate objects (i.e.

property damage) or where violence perpetration occurred indirectly (e.g. grooming individuals who caused injuries to another) were not included. For studies where the presence of physical or sexual acts of violence specifically may be less clear (e.g. intimate partner violence or child abuse which may include emotional abuse or neglect), the full text was screened and only studies that explicitly and independently reported data related to physical or sexual forms of violence as defined were included. Physical and sexual violent outcomes of all severity (e.g. attempted assault, homicide) and frequency (e.g. single event, repeated) were included.

Studies were included if (i) their primary aim was to assess the independent link between CSA and physical and/or sexual violence in adulthood, (ii) they measured CSA and adult physical and/or sexual violence in line with the ages defined above, (iii) they provided quantitative data (iv) they were published in peer review journals and (v) they included and reported male data only or separately from female data.

Studies were excluded if they (i) did not measure CSA independently from other forms of childhood maltreatment (e.g. together with physical and emotional abuse, neglect), (ii) used the same data as another study (in these cases, the study with the most relevant aim or largest sample size was included).

The eligibility criteria were piloted on a small proportion of studies by A.H. and were refined. All abstracts and titles from the search were screened for eligibility according to the inclusion and exclusion criteria by A.H.. 25% of these were independently screened by J.R.B. (second author), blinded to the decisions by the first author. If it was evident that the study failed to meet criteria based on the title and abstract, then it was rejected and did not advance to full-text screening. Studies that were passed by any reviewer were advanced to full-text screening. There was a “near-perfect” agreement between the two reviewers at the initial

screening stage, k = 0.91 (95% CI 0.85 to 0.96), $p < 0.001$. For studies that entered full text screening, A.H. screened all studies and J.R.B. independently screened 25% of these studies. Discrepancies in the inclusion or exclusion of a paper at this stage were resolved through discussion to reach a "perfect" agreement (k = 1) between the two reviewers.

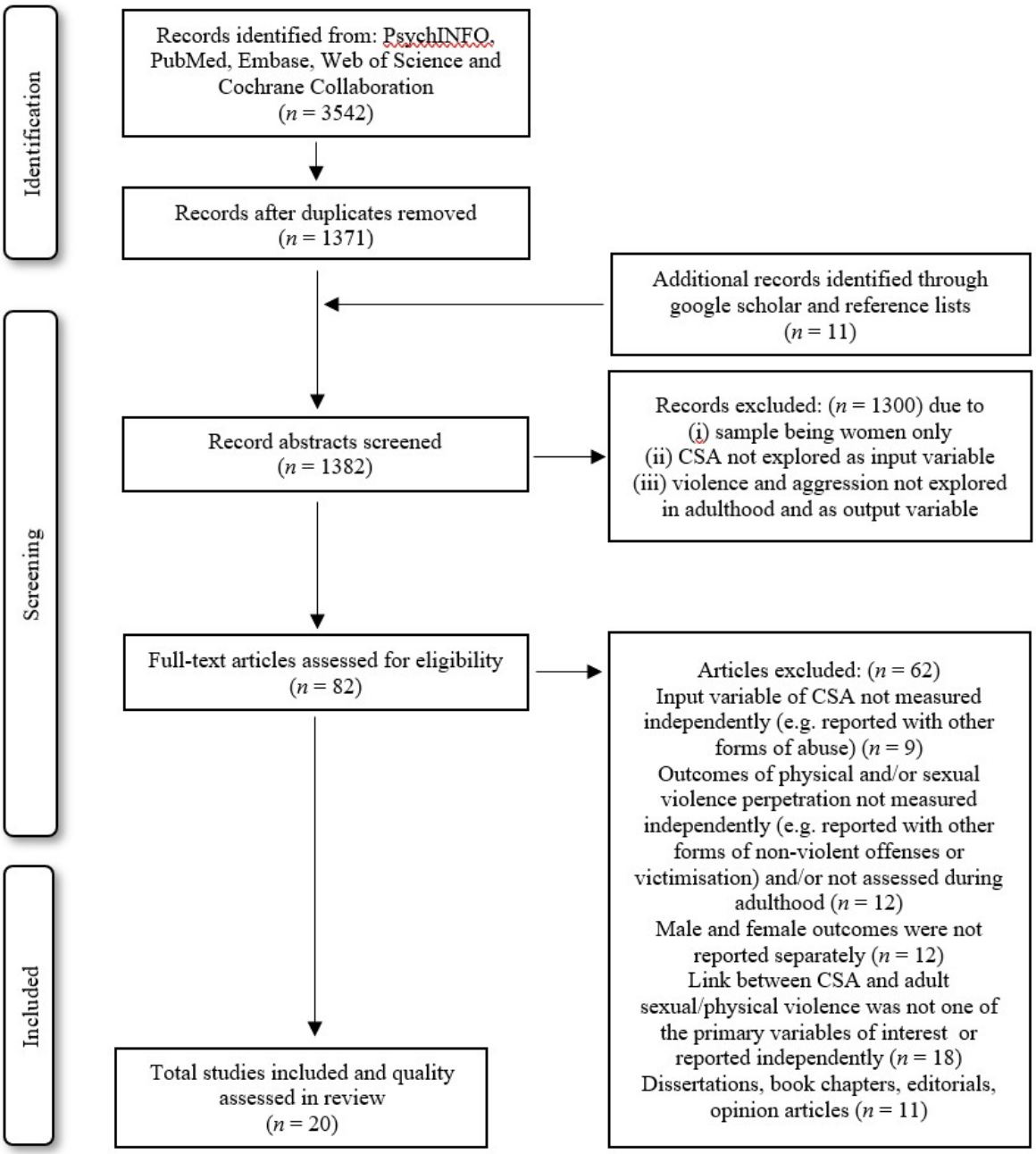

Figure 1.1 PRISMA flow chart of the study selection process

Data extraction

A standardised form was developed and used to extract data to increase the reliability of collected data and minimise potential errors (see Appendix 1.3). A.H. extracted data from all the studies included for analysis and J.R.B. independently extracted data from 50% of the included studies. Any discrepancies that emerged were resolved through discussion. Study information extracted included: source (i.e. authors), geographical location, sample size and demographics, measure of CSA, measure of violence, variables controlled and any other relevant findings.

Quality assessment

The quality of the included studies was assessed using the Standard Quality Assessment Criteria for Evaluating Primary Research Papers from a Variety of Fields (Kmet et al., 2004). This quality assessment provided standardised criteria for measuring various aspects of research methodology, including ratings on clarity of research objectives, appropriateness of design, sample size justification and control for confounds. Three irrelevant items on the quality appraisal tool related to interventional random allocation and blinding of samples were removed (see Appendix 1.4 for the adapted quality appraisal tool). Each criterion had a maximum score of 2 (0 = *no*, 1 = *partial*, 2 = *yes*) and the maximum quality score with the adaptations was 22. Both A.H. and J.R.B. independently conducted quality appraisals for all the studies included and discrepancies in quality ratings were resolved through discussion. There was "substantial" agreement between two reviewers, k = 0.72 (95% CI 0.69 to 0.95), $p < 0.001$. Study quality was classified into three groups based on the agreed score between reviewers; *high* (19-22), *medium* (16-18), and *low* (13-15). Any study that scored lower than 13 was agreed to be excluded from the review to ensure a

minimum level of quality of evidence to synthesise into conclusions, however, no eligible study scored below this number.

Results

Description of Included Studies

The initial search identified 3329 studies, and 20 studies met eligibility criteria after duplicated and non-eligible papers were screened out. The updated search resulted in a further 213 studies, from which no further eligible article was found.

The 20 studies included in this review were published between 1992 and 2022 with a total of 88,585 participants. The mean reported age of samples ranged from 19.7 to 57 years. 11 studies contained male-only and nine contained mixed-gender samples. The majority of the studies were conducted in high-income countries with most originating from the US (*n* =12) as well as the Netherlands, Germany and Canada. A majority of the studies (*n* =11) had a predominantly Caucasian sample. Seven studies did not report ethnic makeup, and two studies had a predominantly Black African sample.

Nine studies included in this review explored the impact of CSA on sexual violence only, eight on physical violence only and three on both sexual and physical violence. Six explored sexual and/or physical violence within the context of intimate partner violence (IPV) only. Nine studies compared samples with versus without histories of CSA on violence outcomes. Five compared samples with or without violent outcomes on reports of CSA and six examined samples on a continuum of CSA and violence outcomes. 17 studies utilised self-report measures and three utilised criminal or court records of CSA and violence. 16 studies utilised a cross-sectional design and four utilised a longitudinal design. To explore the association between CSA and sexual and/or physical violence, univariate (e.g. correlation coefficient) and/or multivariate (e.g. logistic regression) analyses were used. The most

commonly used variables for multivariate analyses included: gender, age, race, childhood victimisation (physical abuse, neglect, witnessing violence, domestic violence), family variables, alcohol use, mental health issues, and dating or gender-related attitudes.

Definitions used across studies

How CSA was defined hugely varied across studies. Some studies required CSA to have occurred before the age of 14 (e.g. Krahé & Berger, 2017; Loh & Gidycz, 2016; Merrill et al., 2001), some before the age of 18 (e.g. Cubellis et al., 2016; de Jong & Dennison, 2017; Harford et al., 2014; Trabold et al., 2015; Whitfield et al., 2003), whilst others left age cut-off points unclear or unreported. A large proportion of studies acknowledged CSA only if it was perpetrated by individuals with particular characteristics, for example, if they were 5+ years or older than the victim, were not a peer and/or was a parent and/or caregiver. Studies also differed on whether CSA was defined as a penetrative or non-penetrative act, physical contact or non-contact act, and there were differences in what severity constituted as CSA (e.g. attempted, threatened or actual). As expected, studies that utilised self-report measures left participants to identify their own CSA experiences and to subjectively interpret what constituted having been “sexually abused as a child”. Studies that utilised more standardised external sources like criminal or court databases to confirm CSA also had differing criteria for CSA. Some studies only included confirmed cases where the perpetrator was found to be guilty, whereas others included cases with any records to suggest CSA victimisation may have been present. A proportion of studies provided single or multiple dichotomous questions to participants to measure CSA, whilst others provided Likert ratings varying in frequency and/or severity of CSA. In both cases, it was common for any positive response to any of the CSA-related questions to be dichotomised by researchers into the CSA victim group.

Defining violence and aggression also varied across studies, with the majority of studies utilising self-reported questionnaires. For studies that utilised external validation of interpersonal violence perpetration, the level and type of validation differed; some required records of sexual and/or physical violence perpetration on public databases whilst others required a guilty charge at court. As expected from the inclusion criteria of this review, studies differed in the level of frequency and severity of violence that they constituted as violence (e.g. from hitting to homicide).

Quality of studies

Based on the Standard Quality Assessment Criteria for Evaluating Primary Research Papers from a Variety of Fields (Kmet et al., 2004), none of the studies included in this systematic review reached the maximum quality of 22 points, nor were any excluded as a result of scoring below the minimum 13 points for quality. Five studies were deemed of high quality, 11 of medium quality and four of low quality.

There were several major methodological issues to note within these studies. Most studies depended on correlational data, which limited their capacity to infer causality and directionality. The majority of studies also utilised retrospective, self-report measures. This may be problematic as studies that conducted longitudinal follow-ups of childhood abuse survivors found that retrospective self-reports were likely to underestimate actual prevalence (Femina et al., 1990). A significant proportion of studies utilised a singular, unvalidated, self-report item to measure CSA by asking whether participants believed they were sexually abused (e.g. Brassard et al., 2022; Cubellis et al., 2016; Fang & Corso, 2008; King, Kuhn, Strege, Russell, & Kolander, 2019). A proportion utilised adapted versions of validated questionnaires (e.g. extracting relevant questions or subscales from existing questionnaires). This can be problematic as adaptations to questionnaires can compromise the reliability and

validity of questionnaires (McDermott et al., 2008). Only three studies included a full, psychometrically validated measure for CSA (Levenson & Grady, 2016; Loh & Gidycz, 2006; Machisa et al., 2016). A minority of studies utilised external records of CSA, i.e. archived court files (i.e. de Jong & Dennison, 2017), offender record files (Dutton & Hart, 1992) and criminal records (i.e. Ogloff et al., 2012). However, given the nature of utilising forensic records and the legal implications of CSA, the definition of CSA for these studies was more stringent and may risk underreporting 'minor' cases of CSA.

Compared to measures of CSA, measures of physical and/or sexual violence were comparatively more standardised and a larger proportion of studies utilised full versions of psychometrically validated measures. However, again, a large proportion of studies in this review made untested adaptations to validated questionnaires, for example selecting relevant subscales (Brassard et al., 2022; Cubellis et al., 2016; Peterson et al., 2018) or items from a specific subscale of a questionnaire (Casey et al., 2016; Teitelman et al., 2017). A small proportion of studies used questionnaires to measure sexual or physical violence outcomes where psychometric validity was not reported or unclear (Krahé & Berger, 2017; Levenson & Grady, 2016; Machisa et al., 2016). Most studies were cross-sectional which made it difficult to disentangle the temporal order of factors. As mentioned previously, longitudinal and prospective analyses (Krahé & Berger, 2017; Loh & Gidycz, 2016) both found that CSA was a predictor of sexual violence at baseline but not at follow-up, emphasising the need to be cautious when interpreting cross-sectional data in this area.

Not only were measures of CSA and/or violence varied, there was limited consensus in eligible studies around common covariates that may confound the relationship between CSA and violence in the field. Some studies opted to control for concurrent adverse childhood experiences, whilst others opted for other potential contributing factors to violence like alcohol use or attitudes.

Additionally, most studies utilised convenience sampling methods of groups that were not representative of the particular populations of interest or the general population of men. Most studies did not justify for the sample population or size nor conducted a-priori power analyses for sample size calculations. Six studies recruited from university student samples, eight from community samples either online or through certain clinics or health programs, five from forensic populations and one from military groups. Within this, only four aimed for representativeness either in the local area, nationally or of the target population of interest (Fang & Corso, 2008; Harford et al., 2014; Machisa et al., 2016; Ogloff et al., 2012). Therefore, a predominant reliance on convenience sampling methods may again be a threat to the validity and generalisability of the findings.

Table 1.1 Summary of included studies (in descending order of quality)

Source	Country Sample	Participant characteristics and dominant ethnicity	CSA measure	Violence measure (PV and/or SV)	CSA-Violence Outcome	Variables Controlled	Other relevant findings	Quality Rating
De Jong & Dennison (2017)	Netherlands Nationally representative criminal sample v. siblings + v. random community sample	*N* = 943 %M = 100% Age ?-? *M* = 45 SD = ? Ethnicity = ?	From archived court files. Three criteria for CSA: before 18, hands-on SA, perpetrator proclaimed guilty (CR)	PV + SV Prospectively in criminal records – general and specific offending – e.g. violent, sexual, property (CR)	Multi: CSA-violent offending (adjusted OR = 6.60; $p < 0.001$) and sexual offending (adjusted OR = 7.19, $p = 0.01$) when compared with the community sample. CSA is not significantly associated with violent offences when compared with siblings (OR 1.48 $p = 0.171$) even after excluding incest cases (OR 1.36, $p = 0.305$).	Exposure (time between birth and end of observation)	Siblings were also more likely to violently offend (OR = 3.77, $p < 0.001$)	20/22
Whitfield et al. (2003)	US Community sample of adult members of the Kaiser Health Plan in San Diego	*N* = 8629 %M = 46% Age ?-? *M* = 57 SD = ? 75% C	Four items (dichotomous) adapted from Wyatt (1985): before 18, sexual experience with a person 5+ years older. Yes to anyone = dichotomised to CSA present (SR) (-)	PV in IPV 1 item from CTS (+) (A)	Multi: CSA-IPV significant for men ($p < 0.001$) CSA-IPV association highest if CSA before age 12 (OR = 3.3, 95% C.I. = 1.8-6.0) compared to after age 12 (OR = 1.8, 95% C.I. = 0.9-3.5)	Age, sex, race, education		19/22
Harford, Yi and Grant (2014)	US & District of Colombia Secondary data from an epidemiological survey	*N* = 34653 %M = ? Age 18+ *M* = ? SD = ? Ethnicity = ?	ACE (SR) (?P) (A) Four items (dichotomous) adapted from Wyatt (1985): before 18, sexual experience with person 5+ years older. Yes to anyone = dichotomised to CSA present (SR) (-)	PV Four items (dichotomous): physical violence, weapon use, violence towards partner. Total categorised to none, 1 or 1+ (SR) (-)	Multi: CSA-PV not significant for men (OR = 1.09, C.I. = 0.86-1.39)	Demographic characteristics, childhood neglect, DV, family dysfunction, mood, anxiety, SU personality disorder, ADHD		19/22
Peterson et al. (2018)	US STI clinics	*N* = 377 %M = 100% Age 18-30 *M* = 23.6 SD = 3.57 78% BA	CTQ – SA subscale (SR) (+) (A); ? CSA definition	SV SSS with enticement subscale removed (SR) (+) (A)	Multi: CSA-SV not significant in final SEM (β = .08, C.I. = 0.09-0.30, $p = .38$)	Final SEM controlled for age, race, anxiety, depression, problem drinking	Final SEM - anxiety helped explain the relationship between CSA + SV	19/22

Table 1.1 (Continued)

Source	Country Sample	Participant characteristics and dominant ethnicity	CSA measure	Violence measure (PV and/or SV)	CSA-Violence Outcome	Variables Controlled	Other relevant findings	Quality Rating
Loh and Gidycz (2006)	US University students	*N* = 325 %M = 100% Age majority 18-19 *M* = ? SD = ? 91.7% C	CSVQ; sexual victimisation before age 14 with someone 5+ years older (SR) (+)	SV SES (SR) (+) CTS (SR) (+) At baseline and then at 3-month follow up	Uni: CSA-SV $\chi 2$ (4, *N* =320) = 4.74, *p* > .05. OR = 6.17 Multi (retrospective): history of perpetration best predicted by CSA, mother-child conflict and dating resolution. Multi (prospective): CSA not included in the final model to predict perpetration.	Baseline: Father conflict resolution, mother conflict resolution, self-conflict resolution Follow-up: As above + history of perpetration		19/22
Norton-Baker et al. (2019)	US College undergraduates	*N* = 873 %M = 27.8% Age 18-55, *M* = 20.15 SD = 4.12 86.9% C	SAS-SR-D (SR) (-) (A); CSA before age 13 and between 13-16. SAS-SR-C (SR) (-) (A) sexual touch, oral or penetrative SA, rape; dichotomised to CSA if answer yes to any	PV LAVA (LAGG, ITO, TVA, MA-IP/AR/LR) (SR) (+)	Uni: CSA significantly associated with LAVA TVA, Reactive and IPV Multi: CSA-PV not significant in men for any other than SA-TVA = β =.094, *SE* = .048, *Beta* = .128, *p* = .049)	Age, PPA, SPA, OPV, PB	CPA (VEQ-R; SR; +) was a stronger predictor of aggression in men	18/22
Trabold et al. (2015)	US Forensic population – Pretrial supervision program	*N* = 274 %M = 73.7% Age 18-62 *M* = 33.9 SD = 10.9 52.2% BA	2 items (Likert-scale) on CSA prior to the age of 18; sexual touch, molestation (1 = never, 5 = very often) then dichotomised (SR) (-)	PV in IPV CTS2 – Physical abuse subscale (SR) (+) (A)	Uni: CSA was significantly associated with moderate and severe IPV (*r* = 0.23, *p* = 0.000) Multi: CSA-moderate IPV was significant for both genders but CSA-severe IPV was not significant for men (ΔR2 = .01, *p* = .17)	Age, education, race, MDD, PTSD	Associations were significant for women	18/22
Levenson and Grady (2016)	US Sexual offenders in outpatient or confinement-based treatment programs	*N* = 740 %M = 93.5% Age “majority” 31-60 *M* = ? SD = ? 68% C	ACE (SR) (+)	SV SVS (SR) (?P)	Uni: CSA-SV not calculated Multi: CSA-SV not significant in multiple regression model (β =0.077, *t* = 1.776, *p* = 0.076)	VA, PA, EN, PN, DV, mental illness in home, incarcerated family member, parents not married, SAb in the home	Having an incarcerated family member was the strongest contributor, followed by PA and SAb	18/22

Table 1.1 (Continued)

Source	Country Sample	Participant characteristics and dominant ethnicity	CSA measure	Violence measure (PV and/or SV)	CSA-Violence Outcome	Variables Controlled	Other relevant findings	Quality Rating
Brassard et al. (2022)	Canada Student sample – college undergraduates	*N* = 189 %M = 100% Age 18-69 *M* = 34.18 SD = 10.38 91.9% French-Canadians	One item (dichotomous) related to SA during childhood/adolescence (SR) (-)	PV in IPV CTS2 – PV and PSV subscale (SR) (+) (A)	Uni: CSA-Physical IPV not significantly correlated Multi: CSA-IPV not significant but authors argued "marginally related" (β = 0.736, *p* = 0.087)	Social desirability, history of family violence	CSA positively related to psychological IPV	18/22
Machisa, Christofides and Jewkes (2016)	South Africa Random selection of households through primary sampling units	*N* = 416 %M = 100% Age majority 18-29 *M* = ? SD = ? Ethnicity = ?	CTQ (SR) (+);	SV and PV in IPV WHO-instrument on physical and sexual IPV (SR) (? P)	Uni: CSA-Physical IPV significant (*p* = 0.05), CSA-Sexual IPV not significant (*p* = 0.1)	None for CSA specifically (just univariate)		18/22
Fang and Corso (2008)	US Secondary data	*N* = 9352 %M = 48.1% Age ?-? *M* = 21.93 SD = 1.87 68.5% C	One item (dichotomous) related to sexual touch, sexual relations (SR) (-)	PV - Longitudinal Five items: group fight, hurting someone to the point of bandages, use or threatened use of weapons, knife or gun use, shot or stabbed someone (SR) (-)	Multi: CSA-IPV significantly increases risk by 17.63% (*p* <0.01) for CSA male v. no CSA. CSA-PV significant (*r* = 0.621, *p* <0.01)	Age, gender, race, family background factors, religiosity during adolescence, adolescent economic disadvantage	Indirect effects of CSA-IPV through youth violence were not significant	18/22
Ogloff et al. (2012)	Australia Forensic records + matched comparison (Australian Electoral Commission) Prospective	*N* = 2759 CSA victims, 2677 matched controls CSA victims at follow-up: %M = 20.2% Age ?-? *M* = 35.58 SD = 11.05 Ethnicity = ?	Criminal records between 1964-1995; contact sexual offending cases, not all requiring actual penetration, average age 10.22 (CR)	SV Offence data from Victoria police database; nature of offence, verdict, sentence (CR)	Uni: 5% of male CSA cases were convicted of a sexual offence compared to 0.6% in the males in the general population (OR = 8.16, 95% C.I. = 2.84–23.42, *p* = 0.0001).	None	Differences were larger with boys with CSA > 12 than those below 12 CSA (2.9%); OR = 3.33, 95% C.I. = 1.53–7.27, *p* < 0.001).	18/22

Table 1.1 (Continued)

Source	Country Sample	Participant characteristics and dominant ethnicity	CSA measure	Violence measure (PV and/or SV)	CSA-Violence Outcome	Variables Controlled	Other relevant findings	Quality Rating
Merrill, Thomsen, Gold and Miller (2001)	US Military sample (3 samples)	*N* = 7850 %M = 100% Age ?-? *M* = 20.1, 19.9, 19.7 SD = 2.3, 2.7, 2.5 71.8%, 64.8%, 63.9% C	SEQ; if there was contact CSA which occurred prior to age 14 with someone 5+ years older who were not peers (SR) (?P) (A)	SV SES (SR) (+) (A)	Uni: CSA was significantly predictive of rape univariably (for three samples, OR = 1.77, 2.14 and 2.46) Multi: CSA was not a significant predictor of rape when mediator variables were included (for three samples, OR = 0.98, 1.12, 1.22)	Alcohol problems and number of sex partners	Additive effect of CPA and CSA on rape.	18/22
King et al. (2019)	US Online Amazon Mechanical Turk	*N* = 489 %M = 100% Age 18-73 *M* = ? SD = ? 83% C	One item (Likert-scale) on whether the participant "believed he was sexually abused prior to age of 16" (0 = never, 4 = very often) (SR) (-)	SV SES-SPF (SR) (+)	Multi: CSA significant predictor of combined SV outcomes $\Lambda(5, 391) = 9.44$, $p < 0.001$ and unshared variance for each dependent measure. CSA-SV is significantly stronger than other forms of maltreatment ($p < .01$)	Age, PPA, DV, EA, OPV, SPA, PB	CSA-SV link magnified with PPA, SPA, exposure to IPV and polyvictimisation.	17/22
Cubellis et al. (2016)	International University students	*N* = 13659 %M = 28.6% Age 18-55 *M* = ? SD = ? Ethnicity = ?	One item (dichotomous) on whether participant "was sexually abused prior to the age 18" (SR) (-)	PV in IPV CTS2 – Physical Assault subscale (SR) (+) (A) PRP (SR) (+)	Multi: Significant CSA-IPV association (ERR = 1.50, Coefficient = 0.49, SE = 0.12, $p < 0.01$)	Gender, age, socio-economic status, cohabitation relationship, relationship length, social desirability, PV victimisation	ASTB-mediated association between CSA and IPV	17/22
Krahe and Berger (2017)	Germany University students at various universities	*N* = 2251 %M = 41% Age 18-30 *M* = 21.3 SD = 2.33 Ethnicity = ?	Three items (Likert-scale) related to sexual touch and penetration before the age of 14 (SR) (-)	SV SAV-S (SR) (-) at baseline and one year later	Uni: CSA-SV for men at baseline significant ($r = 0.09$, $p < 0.001$) but not follow-up. Multi: CSA-SV at follow up not significant.	Sexual perpetration and victimisation in adolescence Follow up: Sexual self-esteem, risky sexual behaviour	CSA-SV at follow up associated via SV at baseline and sexual self-esteem	16/22

Table 1.1 (Continued)

Source	Country Sample	Participant characteristics and dominant ethnicity	CSA measure	Violence measure (PV and/or SV)	CSA-Violence Outcome	Variables Controlled	Other relevant findings	Quality Rating
Teitelman et al., (2017)	South Africa Community sample of a study in an RCT of HIV risk reduction intervention	*N* = 871 %M = 100% Age 18-45 *M* = ? SD = ? Ethnicity = ?, but recruitment area 98% BA	Five items (dichotomous) penetrative/non-penetrative intercourse against will (SR) (-) A yes to any of the 5 dichotomised to yes	PV in IPV CTS2 (SR) (+) (A) prospectively at baseline, 6 months and 12 months	Uni: Chi-squared comparisons; CSA-IPV significantly associated (p < 0.001) when comparing CSA in those who had perpetrated IPV vs not in the past year. Multi: longitudinally (6-12m), CSA victims have significantly higher odds of being IPV perpetrators (OR = 1.787, C.I. = 1.3, p < 0.001) than non-CSA	Age, religiosity, condom-use impulse-control, matriculation, employment status, binge drinking, partner communication	Men who were employed, binge drank, and had lower condom-use impulse-control were more likely to perpetrate IPV	15/22
Dutton and Hart (1992)	Canada Federal inmates – sampled by freezing the daily census and selecting every inmate	*N* = 604 %M = 100% Age ?-? *M* = 34.7 SD = 10.1 75% C	Offender record system files – CSA = SA or other sexual molestation (involvement in child pornography, forced sex with other children), perpetrated by someone 5+ years older (CR)	PV + SV Violent offences > 18 including homicide, SA, threat of injury or death, conspiracy to these acts (CR)	Uni SV: CSA-SV to strangers significant (OR 7.89, p<0.001) and family members (OR 5.28, p<0.01) compared to those with no abuse experiences Uni PV: No significant relationship between CSA and PV	None	CPA significantly increased the risk of violent offending (all types)	15/22
Casey et al. (2017)	US Online community sample	*N* = 555 %M = 100% Age 18-25 *M* = 20.6 SD = 2 20.9% C, 19.8% BA	Four items (Likert-scale) on CSA of someone 5+ years older, around sexual touch and penetration (SR) (-)	SV in IPV Seven items from the SES (SR) (+) (A)	Uni: CSA-IPV was significantly associated (0.36, p <.001) and was the only ACE associated with perpetration Multi: CSA indirectly associated with IPV through hostile masculinity in multivariate analyses (0.29, p <.001)	Hostile masculinity, impersonal sexual behaviour and attitudes, SU	Significantly mediated by hostile masculinity (b =.04, p =.01)	15/22
Carr and VanDeusen (2004)	US Student population – undergraduates from one university	*N* = 99 %M = 100% Age 18-23 *M* = 20 SD = 1.6 90% C	Items related to sexual victimisation as boys selected from Finkelhor items of childhood sexual experiences (1979) (SR) (-) (A)	SV SES (SR) (+)	Uni: CSA-SA bivariate association was significant for SA of children (r = 0.28, p <.01), SV and PV to dates (r =.20, p <.05 and r =.31, p <.01 respectively) Multi: CSA did not contribute significantly to predicting SV in multivariate calculations	Pornography use, alcohol use, gender attitudes	Acceptance of IPV, sexual conservatism, pornography and alcohol use also are associated with SV.	14/22

Association between CSA and physical violence perpetration by men

Eleven studies in this review examined the association between CSA and physical violence. Seven studies assessed this at a multivariate level only, two at a univariate level only and two at both univariate and multivariate levels of analysis. A majority of the 11 studies were of medium quality (n = 6), and a minority were of low quality (n = 2) and high quality (n = 3).

Of these studies, five reported a significant association between CSA and physically violent outcomes for men (i.e. self-report of physical violence, within the context of IPV or record of violent offences). One study was of high quality (Whitfield et al., 2003), three of medium quality (Cubellis et al., 2016; Fang & Corso, 2008; Machisa et al., 2016) and one of low quality (Teitelman et al., 2017). One study reported CSA being significantly associated with physical IPV at a univariate level through a random selection of households in South Africa (Machisa et al., 2016). Three studies found significant associations at a multivariate level. Cubellis et al. (2016) sampled 13,659 university students internationally and found that there was a significant CSA-physical IPV association (Event Rate Ratio (ERR) = 1.50, Coefficient = 0.49, SE = 0.12, $p < 0.01$) even when controlling for basic demographic factors as well as factors such as cohabitation relationship commitment, relationship length, social desirability and physical violence victimisation. The association decreased but remained statistically significant for men when anti-social traits and behaviours were included as Level 1 predictors (from ERR = 1.50 to ERR = 1.33). Whitfield et al. (2003) also found significant CSA-physical IPV associations at a multivariate level (p <.001) when comparing men with CSA histories to those with no CSA histories and found that the association was highest if CSA occurred before the age of 12 (OR = 3.3, 95% CI =1.8-6.0) compared to after age 12 (OR = 1.8, 95% CI = 0.9-3.5). Fang and Corso (2008) found that CSA significantly increased the risk of physical violence by 17.63% compared to those who have no histories of CSA (p

<.01), and was significantly associated withphysical violence even when controlling for basic demographic variables, family background factors, adolescent economic disadvantage and level of religiosity. Finally, one longitudinal study (Teitelman et al., 2017) followed up participants at 6 and 12 months and found significant associations between CSA and physical IPV at both univariate and multivariate levels of analysis, with findings from multivariate analysis suggesting that CSA victims had significantly higher odds of being IPV perpetrators in the past year than those who had no CSA victimisation history (OR = 1.787, CI = 1.3, *p* <.001). However, the study sample was sourced from an HIV risk reduction prevention program which may not be generalisable to the wider population.

On the other hand, three studies reported on no significant associations between CSA and physical violence in men. One was of high quality (Harford et al., 2014), one of medium quality (Brassard et al., 2022) and one of low quality (Dutton & Hart, 1992). One study reported this at univariate level only, one at multivariate level only, and one on both levels of analysis. On a univariate level of analysis, Dutton & Hart (1992) examined a representative sample of federal inmates and found no significant relationship between CSA and violent offences (homicide, threat of injury and death, conspiracy to commit any of these acts) over the age of 18. On a multivariate level of analysis, Harford et al. (2014) utilised secondary data from a National Epidemiological Survey on Alcohol and Related Conditions (NESARC) and found that CSA was not significantly related to physical violence for men when controlling for demographic characteristics, childhood victimisation (childhood neglect, domestic violence), internalising and externalising difficulties (mood, anxiety, personality disorder, ADHD and substance use). Finally, Brassard et al., (2022) surveyed 189 college undergraduates in the US and found that CSA and physical IPV were not significantly correlated at univariate levels and “marginally related” on multivariate levels ($\beta = 0.736$, $p = 0.087$) when controlling for social desirability and history of family violence.

Lastly, three studies found mixed results when examining the association between CSA and physical violence in men. One was of high quality (de Jong & Dennison, 2017) and two were of medium quality (Norton-Baker et al., 2019; Trabold et al., 2015). Trabold et al. (2015) examined a forensic population of individuals involved in a pretrial supervision program and found that whilst CSA was significantly associated with moderate and severe physical IPV on a univariate level, CSA was only significantly associated to moderate physical IPV but not severe physical IPV for men when controlling for basic demographic characteristics, depression and post-traumatic stress disorder. Norton-Baker (2019) surveyed 873 US college undergraduates and found that on a univariate level, CSA was significantly related to certain subscales of the Lifetime Assessment of Violent Acts (LAVA) including Trouble from Violent Acts, Reactive Acts, and Intimate Partner Acts, but not Lifetime Aggressive Acts, Motivated Acts or Injuries to Others. When controlling for age, parent physical abuse, sibling physical abuse, physical violence, observed parental violence and peer bullying, none of the aggregate or subscales were significantly associated with CSA except for the Trouble from Violent Acts subscale. On the other hand, CSA links with physical violence were significant in women and childhood physical abuse was a stronger predictor of adult aggression for men. Lastly, in an interesting study conducted by De Jong and Dennison (2017) where a nationally representative sample of offenders were first compared with a population-based matched comparison group and then subsequently with their siblings, they found that CSA was a significant predictor of violent offending (adjusted OR = 6.6; $p < .01$) when compared to the general population, after controlling for exposure. However, CSA was no longer a significant predictor of any offences, including violent offences, when compared with the offenders' siblings, even after excluding cases where incest may have occurred. Interestingly, the association between CSA and violent offending remained significant for women even when compared with their non-offending siblings.

Overall, the studies suggest that there is limited evidence to confidently conclude an association between CSA and physical violence. A proportion of medium to high quality studies had mixed results or did not support this association, notably a high quality study that showed no significant association (Harford, Yi and Grant, 2014) and a study where results were mixed and depended on the comparison group chosen (De Jong and Dennison, 2017).

Association between CSA and sexual violence perpetration by men

Eleven studies in this review examined the association between CSA and sexual violence outcomes. Four of these studies assessed this at a multivariate level only, three at a univariate level only, and four at both a univariate and multivariate level. The majority of the studies were of medium quality (n = 5), some were of high quality (n = 3) and low quality (n = 3).

Of these studies, four reported a significant association between CSA and sexual violence perpetration in men. Two were of medium quality (Casey et al., 2016; Dutton & Hart, 1992) and two were of low quality (King et al., 2019; Ogloff et al., 2012). Two studies found significant univariate associations, both examining the effect of CSA on violent offences (Dutton and Hart, 1992; Ogloff et al., 2012). Dutton and Hart (1992) found that CSA significantly increased the risk of sexually violent offences towards strangers (OR = 7.89, p <0.001) and family members (OR = 5.28, p <0.01) compared to those with no abuse experiences. Ogloff et al. (2012) found that 5% of male CSA cases were convicted of a sexual offence compared to 0.6% in male in general population (OR = 8.16, 95% C.I. = 2.84–23.42, p = 0.0001) and that men who experienced CSA above the age of 12 had three times increased risk of being convicted with a sexual offence compared to men who experienced CSA below the age of 12 (OR = 3.33, 95% C.I. = 1.53–7.27, p <0.001). On a multivariate level only, King et al. (2019) utilised an online community sample and found that CSA was a

significant predictor of frotteurism, attempted coercion, attempted rape, attempted coercion and completed rape when controlling for various other adverse childhood experiences. CSA had an unshared variance for all of these measures and was significantly stronger than other forms of maltreatment. To note, they found that the link between CSA and sexual violence was magnified with other adverse childhood experiences like parental and sibling physical abuse, exposure to IPV and higher levels of polyvictimisation. Lastly, also utilising an online sample, Casey et al (2017) found significant associations between CSA and sexual violence perpetration on both on a univariate level ($r = 0.36$, $p < .001$) and indirectly on a multivariate level via hostile masculinity, whilst controlling for impersonal sexual behaviour and attitudes and substance use.

In contrast, three studies found no significant association between CSA and sexual violence perpetration in men. One was of high quality (Peterson et al., 2018) and two were of medium quality (Levenson & Grady, 2016; Machisa et al., 2016). One study found no significance on a univariate level (Machisa, Christofides and Jewkes, 2016). Two studies found no significant relationship between these two variables in multivariate analyses, one sampling men in STI clinics (Peterson et al., 2018) and the other examining men who were sexual offenders in a treatment program (Levenson & Grady, 2016). The structural equation modelling conducted by Peterson et al. (2018) controlled for age, race, anxiety, depression and problem drinking whilst Levenson & Grady (2016) controlled for factors related to other adverse childhood experiences like verbal and physical abuse, emotional neglect, domestic violence, incarcerated family members as well as substance abuse at home and parental marital status. Levenson & Grady (2016) found that within forensic populations, sexual violence offences were not predicted by CSA, but instead best predicted by incarcerated family members, followed by physical and then substance abuse.

Four studies reported mixed results. Half of these were of high quality (de Jong & Dennison, 2017; Loh & Gidycz, 2016), one of medium quality (Krahé & Berger, 2017) and one of low quality (Carr & Vandeusen, 2004). Similar to the results on physical violence outcomes, De Jong and Dennison (2017) found that men who had a CSA history were around 7 times more likely to sexually offend than a population-based comparison group. However, CSA was no longer a significant predictor of any violent offence when compared with siblings with no CSA history, even after removing incestual cases. Secondly, two longitudinal studies found that CSA was a predictor of sexual violence outcomes at baseline but not at follow-up (Loh and Gidycz, 2006; Krahe and Berger, 2017). On a univariate level, Loh and Gidycz (2006) found that CSA predicted sexual aggression at baseline but not at a follow-up of 3 months. They reported that 80% of men who reported experiencing CSA with physical contact had committed at least one act of physical aggression, compared to 40% of men who experienced CSA with no physical contact and 30% of men who did not report any experiences of CSA. Men with a CSA history were around six times more likely to commit sexual assault. However, they found that only 5% of this was found to be attributable to CSA. On a multivariate level, when controlling for self and family conflict resolution strategies, CSA was one of the main predictors for retrospective analyses of sexual violence, but the same was not found for prospective analyses. Using a step-wise likelihood ratio model, they found that only self-conflict resolution was a stable predictor of sexual violence retrospectively and only history of sexual violence was a stable predictor of sexual violence perpetration at follow up. Supporting this, Krahe and Berger (2017) also found a significant association between CSA and sexual violence at baseline ($R = 0.09$, $p < 0.001$) but not at follow-up at one year. They found that the relationship between CSA and sexual violence at follow up may be mediated by sexual violence at baseline and level of sexual self-esteem. Lastly, Carr and Van Deusen (2004) found that CSA was univariately significantly associated

with sexual assault of children (R = 0.28, p <.01) and dates (R =.31, p <.01), CSA did not contribute significantly in predicting sexual violence in multivariate calculations when controlling for pornography use, alcohol use and gender attitudes.

Overall, the studies suggest that whilst there may be an association between CSA and sexual violence, the association may be lost when potential covariates are considered (Peterson et al., 2018; Levenson and Grady, 2016) or if examined longitudinally and prospectively (Krahe and Berger, 2017; Loh and Gidycz, 2006). Given the majority of the high quality studies either suggested no significant association or mixed results, evidence to support the association between CSA and sexual violence in men is arguably more limited.

Discussion

The aim of this review was to critically examine the evidence around the association between being a male victim of CSA and later interpersonal violence perpetration (physical or sexual) in adulthood. The results and quality of twenty studies were evaluated in the current review. Overall, the synthesis of these studies provided limited support for an elevated risk of perpetration of interpersonal violence in men, both sexual and physical, as a result of CSA. There is some evidence that this association may be moderated and mediated by a multitude of factors including other adverse childhood experiences like childhood physical and emotional abuse and neglect and family factors, substance/alcohol use as well as individual factors like conflict management strategies and men's attitudes towards sex, women and masculinity. Most studies that found significant associations between CSA and violence were correlational studies that utilised retrospective and cross-sectional methods. Results were more mixed in studies that utilised longitudinal and prospective designs, utilised comparison groups and/or included multivariate analyses that accounted for polyvictimisation factors. In light of the methodological issues highlighted through the systematic quality appraisal, this review highlighted that any conclusions drawn from the current literature must be interpreted cautiously as the studies varied widely in quality and were heterogeneous in terms of study methodology and operationalisation of CSA and violence outcomes. Methodological limitations common in this area severely restrict the ability to understand the long term consequences of CSA in men.

The current review suggests that existing evidence provided only limited evidence of an association between CSA and later physical and sexual violence in men. The association was found predominantly in studies utilising retrospective and cross-sectional designs. To note, there were good quality studies where no association was found in those with longitudinal designs (Krahé & Berger, 2017; Loh & Gidycz, 2016). This lack of association

was also found in a high quality study by de Jong and Dennison (2017) that did not depend on self-reported recall of CSA, which is important given manyof the studies that utilised self-report measures that may be vulnerable to recall bias (Raphael et al., 2001).

The results of the present review are consistent with previous systematic reviews in the literature. For example, in a recent systematic review that explored the association between CSA and sexual offending (Papalia et al., 2018), authors found that the majority of research provided support for the association between CSA and violent offending, that there were methodological issues inherent in these studies and also found that results were more mixed in studies that used prospective and longitudinal designs. Similarly, in a systematic review on the association between CSA and conduct disorder by Maniglio (2015), the association was tentatively supported alongside a strong acknowledgement of the methodological limitations common in the studies and that the association may be a result of reverse causation or direct and indirect effects of other factors.

There were limitations to the current review. First, due to the heterogeneity of study designs and samples, it was not possible in the current review to conduct a meta-analysis and provide a homogenous statistical estimate of the association between CSA and interpersonal violence. Secondly, the current review excluded qualitative studies which, within the context of significant methodological issues in quantitative studies, may have provided some richer insights into the experiences of CSA and how this may link or not link with violence perpetration in adulthood. The conclusions of this review examined results from studies that were not of high quality. Lastly, though the inclusion criteria of the review required the sample age to be 18 or above, many of the included studies contained measures which asked participants about violence from 14 onwards, which may not provide a clear picture of the long-term effects of CSA on violence in adulthood.

There were several theoretical implications that the findings of this review may speak to. In this review, it has been found that there was only limited support for the common assumption in the literature that 'violence begets violence' or that there is an 'intergenerational cycle' of violence (e.g. Ehrensaft et al., 2003; Widom, 1989) when specifically examining it from an angle of CSA on interpersonal violence in men. As mentioned previously, this assumption is challenged due to the numerous methodological limitations of studies that support this theory as well as a small but substantial proportion of high quality studies that did not find this association or where results were mixed. In examining the effect of CSA on sexual violence and physical violence separately, the findings challenged the notion that there is specificity in the effects of the intergenerational cycle of violence based on the type of abuse given there were mixed results on the association between CSA and sexual as well as physical violence. Results are thus against existing arguments that CSA is associated with an increased propensity of sexual violence only (e.g. Drury et al., 2019). In fact, there were more high and medium quality studies that supported the association between CSA and physical violence than there were for studies on sexual violence.

In conclusion, the theoretical notion of an intergenerational cycle of violence was found to have limited support in this study. The widespread assumption that sexually abused boys are uniquely at risk to become sexually violent as men was only tentatively supported in this review. Methodologically, most studies were retrospective and cross-sectional, and there was limited convincing evidence from prospective studies to support the association, further complicated by mixed results from high quality studies. Future research should aim to utilise longitudinal and prospective designs, include comparison groups and incorporate potential confounding factors like other adverse childhood experiences into analyses. This review highlighted the prevalence of studies that utilised unvalidated measures or validated measures

that have been adapted with limited justification. Therefore, the use of psychometrically validated measures is recommended for future studies to improve the methodological quality and validity of results. Future studies could consider limiting the dichotomisation of CSA as an input variable to provide further insights into the nuances of the effect of varying degrees and types of CSA on interpersonal violence in men. Lastly, future reviews may consider higher stringency on quality inclusion (e.g. medium and high quality only) and less stringency on age limits (i.e. inclusion of studies on adolescent male violence) to further the understanding of the unique impact of the long term impact of CSA on males.

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Service Improvement Project

Improving outreach output to aspiring psychologists from disadvantaged socio-economic backgrounds in the Oxford Institute in Clinical Psychology Training and Research

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Abstract

There is increasing recognition and action in recent years to widen participation in the clinical psychology workforce. However, much of the recent efforts have focused predominantly on diversity characteristics of ethnicity and race and much less so on other

equally important diversity characteristics like socioeconomic status or class. The aim of this project was to examine ways in which the Oxford Institute in Clinical Psychology Training and Research (OXICPTR) could improve their outreach output. This project was a mixed-methods study that contained three stages. In the first stage, admissions data related to socioeconomic status from the OXICPTR was compared with admissions data nationally across all Doctorate of Clinical Psychology (DClinPsy) courses. Secondly, the experiences of from 275 trainee and aspiring clinical psychologists self-identifying as from a socioeconomically disadvantaged background were surveyed and thematically analysed. Findings were summarised in terms of (i) the practical and perceptual barriers they have faced in their clinical psychology journey and (ii) their perceptions of Oxford as a training course. Lastly, 32 sixth-form students from disadvantaged schools were surveyed to explore their needs to be supported towards a career in clinical psychology. Based on these findings, recommendations for the Oxford Institute in Clinical Psychology Training and Research in terms of future outreach efforts were provided.

Keywords: Clinical psychology; Diversity and inclusion, Outreach.

Improving outreach output to aspiring psychologists from disadvantaged socio-economic backgrounds in the Oxford Institute in Clinical Psychology Training and Research

Introduction

Improving the diversity of the clinical psychology workforce in the long term should be a priority to ensure that the profession becomes more representative of the population that it serves. Despite decades of discussion and recognition of this issue, efforts to remediate the underrepresentation of minority groups have largely been deemed ineffective or insufficient (Turpin & Coleman, 2010). Therefore, it is important to explore sustainable and effective practices to widen participation in the career for those currently underrepresented in the workforce.

There has been a continued interest in improving the diversity of the clinical psychology workforce in recent years, with several concurrent directions that Doctorate in Clinical Psychology (DClinPsy) courses in the United Kingdom have been taking to work towards this direction. Alongside reviewing selection processes and mentoring schemes, outreach activities form a core part of 'positive action' initiatives. Outreach attempts to reduce barriers, improve access, and raise career aspirations (Connell-Smith & Hubble, 2018) for those in marginalised groups. According to the Standards for the accreditation of Doctorate programmes in Clinical Psychology (The British Psychological Society, 2019), "Programmes should take active steps, including outreach activity, to widen access to entry to the profession of clinical psychology, aiming for diversity within trainee cohorts, and must produce documentary evidence of these strategies".

Despite clear expectations that courses should produce evidence for outreach output, very little is publicly known about what the Oxford Institute in Clinical Psychology Training and Research (OXICPTR) has done in this area. This is not a unique issue to OXICPTR – currently, public documentation and evaluation of outreach activity are scarce across clinical psychology doctorate courses in the UK. The lack of transparent data around outreach output, in terms of what content is shared and how the target audience is reached, makes it difficult to understand and share whether current practices are working and how they can be improved.

Of particular interest to this service improvement project is exploring how outreach efforts of OXICPTR can best serve young people, particularly those who are in sixth form, from a low socio-economic (SE) background, living within the training programme's catchment area. Although all doctorate programmes have received funding from Health Education England (HEE) to improve equity of access for race and ethnicity, and intersectionality will likely be considered as part of the initiative, the current focus may eclipse the support individuals from low SE backgrounds from all ethnic and racial backgrounds require to feel supported in their journey.

It is important to address the gap in which individuals of a low socio-economic status (SES) appear to be underrepresented at the application stage, compared to those from high SES and are less likely to be offered a training place. Based on the most recent Equal Opportunities Data (Clearing House for Postgraduate Courses in Clinical Psychology, 2019), the percentage of applicants for all courses from POLAR Quintile 1 (lowest 20% participation rate in Higher Education - see Appendix 2.3 for details on POLAR classification) was 8.1%, compared to 26.3% from Quintile 5 (highest 20% participation rate in Higher Education). Importantly, whilst the overall percentage of successful applicants was 15.6%, the percentage of successful applicants from Quintile 1 was 11.6% compared to 20.4% from Quintile 5. Whilst the underlying contributing factors for this are likely multi-faceted, low SES may affect A-level and university grades (Goodman & Gregg, 2010), and low grades are likely to decrease one's likelihood of a successful DClinPsy application (Scior et al., 2007). Whilst outreach on its own may unlikely be able to directly address all of these issues, it can play a role in helping raise awareness of the career, debunk myths and provide accurate information about clinical psychology in what are formative years for the future cohorts of clinical psychologists.

From discussions across 2020 and 2021 with the OXICPTR Outreach Lead and previous OXICPTR trainees involved in outreach for the institution, the most recent outreach activities occurred in 2018 with the Oxford Spires Academy, Bucks New University, and UNIQ summer school. A limited amount of feedback was recorded from these outreach activities. There was no documented activity on outreach activities in 2020 and 2021, which could be attributed to COVID-19. A few events before these years occurred however systematic documentation was limited to meeting minutes and was not publicised. Several issues were also identified based on discussions and exploration of meeting minutes: (1) the level of trainee and staff engagement of outreach was variable dependent on available individuals of any given cohort of course staff and trainees that are willing and/or can conduct outreach; (2) handover of outreach material posed a challenge, with both outreach material and its outcomes either not recorded or not handed over through the 'generations' of those involved in outreach i.e. disappearing with the individual who was in charge at the time; (3) outreach formats relied on existing relationships with individual schools; and (4) feedback was not consistently or formally sought out. In rare cases where feedback was sought, there were no formal processes to ensure this informed future output.

It is hoped that findings from this project will inform and improve the content and way in which outreach activities are delivered and documented by OXICPTR and ensure that outreach content is relevant and useful for those who participate. Recommendations for the training course will be provided.

Research questions

(1) Are applicants and trainees from a low SE background (defined by POLAR classifications) underrepresented on the OXICPTR course, and how does this compare with national data?

(2) What are the barriers and motivations to applying to the OXICPTR course, from the perspective of aspiring or trainee clinical psychologists self-identifying as being from a low SE background?

(3) How does one's SE background impact the pursuit of clinical psychology, from the perspective of aspiring or trainee clinical psychologists self-identifying as from a low SE background?

(4) What would sixth-form students from socioeconomically disadvantaged areas want from clinical psychology outreach teams, in terms of content and medium?

(5) In light of findings from Questions 1-4, what recommendations can be made to improve the underrepresentation of those from low SE backgrounds and outreach activity output by OXICPTR?

Method

The project was split into 3 main phases, utilising a mixed-methods approach.

Phase 1: Examining Historical Data from OXICPTR v.s. National Data

Historical data on the representation of SES of applicants and acceptances from OXICPTR were compared against data aggregated nationally (i.e. all DClinPsy courses across the UK including OXICPTR). Consent was obtained from the OXICPTR admissions tutor to access this data between 2015 and 2020. National data was accessed through the Clearing House website (https://www.leeds.ac.uk/chpccp/). Data on SES, retrieved by both sources, were already classified through POLAR (i.e. Participation Of Local AReas). The POLAR classification system measures the proportion of young people attending university within the local area, based on one's postcode through UK census data. With POLAR, SE status is segregated into five quintiles. 20% of areas with the lowest participation rate are designated into Quintile 1 and 20% of areas with the highest participation rates are designated into Quintile 5. Quantitative analyses were used to explore whether there were any significant differences between the representation of each SES quintile of applicants, acceptances and success rate in OXICPTR compared to the national data over this period.

Phase 2: Survey of Aspiring and Trainee Psychologists from Socio-economically Disadvantaged Backgrounds

Aspiring and trainee clinical psychologists, self-identifying as from a socio-economically disadvantaged background across the UK were invited to complete an online survey. The survey aimed to explore how they felt their SE background interacted with their experiences of pursuing clinical psychology, but also what motivated or deterred them from applying to OXICPTR. Two trainee clinical psychologists self-identifying as from a socio-economically disadvantaged background and two OXICPTR staff members provided feedback to the pilot version of the questionnaire. The final version was advertised via social media (Instagram and Twitter).

The survey asked for demographic information on the respondents' SE characteristics, stage in their clinical psychology journey, and whether they had ever applied to, or was a trainee at, Oxford. Due to the complexities of SES, demographic information was not used as a screening tool to determine whether someone was socio-economically disadvantaged or not, but rather as a way to collect descriptive information on the overall SE-related characteristics of respondents. Open-ended questions on respondents' experience on how their background interacted with their experiences and attitudes towards Clinical Psychology, motivations and deterrents from applying to OXICPTR and suggestions to OXICPTR on how to improve outreach and representation were asked.

Inductive thematic analysis (Braun and Clarke, 2006) was used to aid the understanding of the subjective realities of the respondents (see Appendix 2.7 for the author's positionality statement). Following Braun and Clarke's six-step process (familiarisation, initial coding, searching for themes, reviewing themes and defining themes and final summary). Responses were collected through Qualtrics and the data was transferred to NVivo 12 (QSR International), where the author familiarised themselves with the data by reviewing all the answers and writing down potential themes by hand. Subsequently, initial coding was conducted and each node was reviewed individually to be collated into congruent themes. This was supported through the use of conceptual maps drawn out on paper in mind map form, with each survey question used as the central bubble, and themes as secondary bubbles (see Appendix 2.8 for examples of conceptual maps). These conceptual maps were then reviewed and discussed with the second and third authors. Themes were then defined and the data was reviewed again, with the process of choosing the label of each theme again overseen by research supervisors.

Phase 3: Survey of High School Students from Schools in Socio-economically Disadvantaged Areas

A cross-sectional, self-report online questionnaire was conducted in Phase 3, focused on exploring ways in which outreach from OXICPTR could be helpful to support a career in clinical psychology through the perspective of sixth-form students coming from socio-economically disadvantaged areas. The Outreach Lead and Access Officer from the University of Oxford provided feedback on the pilot version of the questionnaire. The sample was recruited through (1) collaboration with St. John's Inspire Programme team, a programme run in association with the Access and Outreach team of St. John's College, Oxford that encouraged online contact for individuals in "Year 9 to 13s from non-selective state schools", and (2) collaboration with the Head of Sixth form at the North Oxfordshire Academy, a co-educational academy school in Banbury, Oxfordshire who shared the questionnaire with sixth-form students studying Psychology at A-levels. The questionnaire aimed at understanding what sixth-form students would want (content) from the outreach team and how they would want it (medium).

Results

Phase 1: OXICPTR data vs. National Data (all courses)

Table 2.1

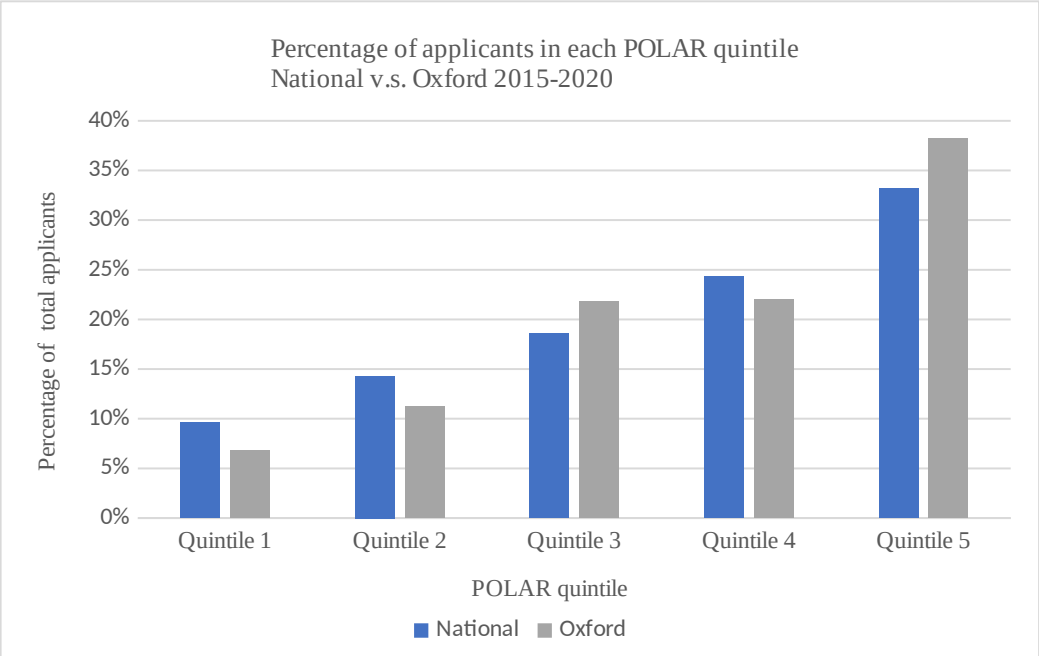
Data of applicants and acceptances at OXICPTR and National (all courses) from 2015-2020

Factor	No. of applicants*	% of applicants*	Total no. of acceptances*	% of acceptance *	% of success from applied to accepted*
Oxford 2015-2020					
No. of applicants*	2771	100.0%	103	100.0%	3.7%
Quintile 1	189	6.8%	6	5.8%	3.2%
Quintile 2	311	11.2%	11	10.7%	3.5%
Quintile 3	603	21.8%	18	17.5%	3.0%
Quintile 4	610	22.0%	21	20.4%	3.4%
Quintile 5	1058	38.2%	47	45.6%	4.4%
National 2015-2020					
No. of applicants*	17719	100.0%	3120	100.0%	17.6%
Quintile 1	1706	9.6%	213	6.8%	12.5%
Quintile 2	2540	14.3%	413	13.2%	16.3%
Quintile 3	3287	18.6%	515	16.5%	15.7%
Quintile 4	4312	24.3%	771	24.7%	17.9%
Quintile 5	5874	33.2%	1208	38.7%	20.6%

**Calculations excluded applicants who preferred not to disclose their SE background*

Figure 2.1

Percentage of applicants in each POLAR quintile - National v.s. Oxford 2015-2020



Both OXICPTR and national data suggested that there were substantially more applicants from higher quintiles than from lower quintiles (Figure 2.1). In OXICPTR, applicants from Quintile 1 represented 6.8% of the total applicants over the 5 years compared to 38.2% from Quintile 5. A similar trend of differing representations from each quintile can be seen with national data, with 9.6% of applicants over the past 5 years identifying as from Quintile 1 compared to 33.2% from Quintile 5. Chi-square tests showed significant differences when comparing the distribution of applicants across quintiles of OXICPTR applicants using the distribution of national data as a benchmark, χ^2 (4, n = 2638) = 96.2, p = .01.

Figure 2.2

Percentage of acceptances in each POLAR quintile - National v.s. Oxford 2015-2020

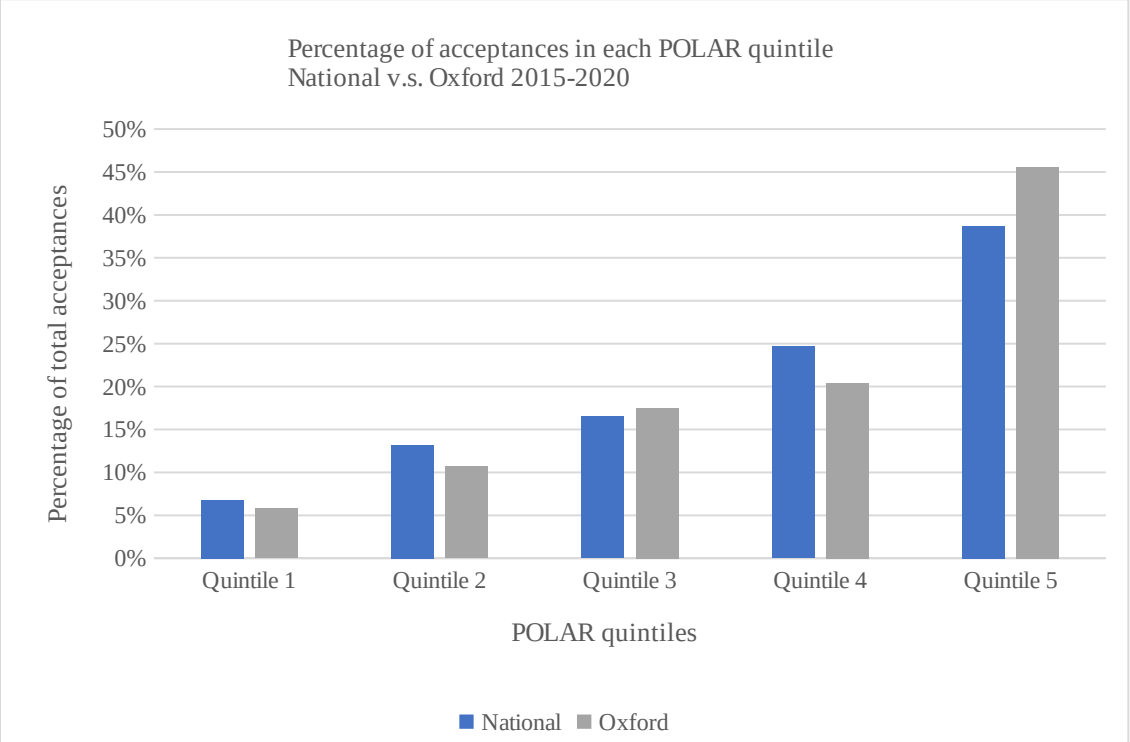


Figure 2.2 shows the percentage of individuals who accepted a place in OXICPTR vs. the percentage of those who accepted a place nationally, segregated into respective POLAR quintiles. Again, in both OXICPTR and national data, there is a substantially higher representation of individuals who have an accepted place from higher quintiles than lower quintiles. Chi-square tests showed no significant differences when comparing the distribution of applicants across quintiles of OXICPTR applicants using the distribution of national data as a benchmark, χ^2 (4, n = 103) = 2.77, p > .05. This suggests that there were no significant differences between the quintile distributions of OXICPTR acceptances in comparison to the quintile distributions of acceptances from national data.

Figure 2.3

Percentage of success from applied to accepted OXICPTR 2015-2020

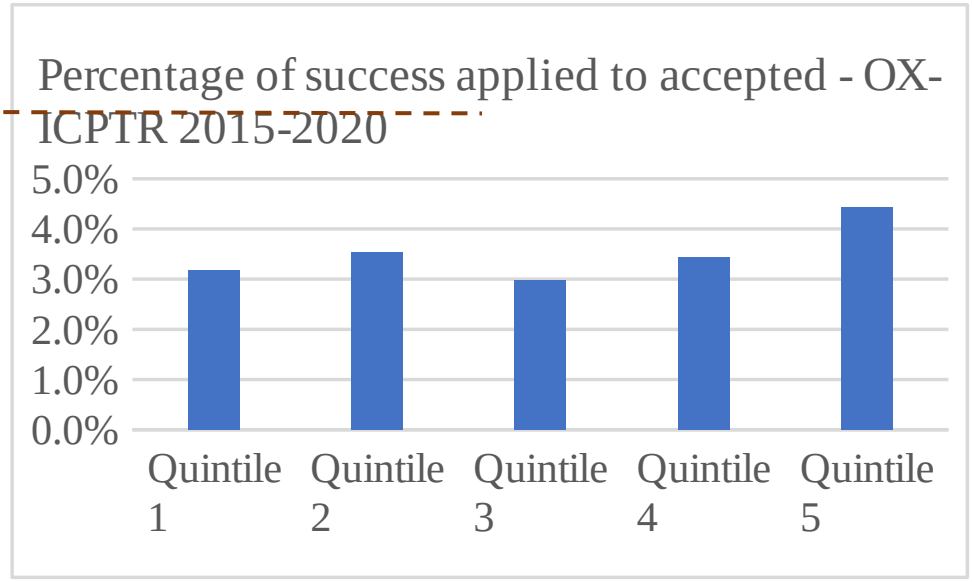


Figure 2.3 shows the percentage of success of applicants in being accepted into OXICPTR at each quintile. The dotted line represents the overall acceptance rate of OXICPTR over 2015-2020. Chi-square tests showed no significant differences between the percentage of success from each quintile when compared to the overall acceptance rate, χ^2 (4, n = 103) = 3.21, p > .05.

Phase 2: Qualitative Survey of Aspiring or Trainee Clinical Psychologists from Socio-Economically Disadvantaged Backgrounds

Table 2.2

Demographic characteristics of respondents

Characteristic	n	%
Total respondents	275	
Stage in psychology career		
Aspiring Clinical Psychologist	222	80.73
Trainee Clinical Psychologist	48	17.45
Other	5	1.82
Highest level of qualifications by respondents' parent(s) or guardian(s) by age 18		
No formal qualifications	49	17.82
Qualifications below degree level	11	8
High school level qualifications	124	45.09
At least one degree qualification	77	28
Don't know	1	0.36
Prefer not to say	0	0
Other	2	0.73
Occupation of highest income earner in the household at age 14		
Modern professional occupations	28	10.18
Clerical and intermediate occupations	36	13.09
Senior managers and administrators	43	15.64
Technical and craft occupations	35	12.73
Semi-routine manual and service occupations	51	18.55
Routine manual and service occupations	18	6.55
Middle or junior managers	37	13.45
Traditional professional occupations	11	4
Long term unemployed	13	4.73
Retired	2	0.73
Not applicable	1	0.35
Don't know	0	0
Prefer not to say	0	0
Type of school mainly attended between ages 11 to 16		
State-run or state-funded school – selective on academic, faith or other grounds	193	70.18
State-run or state-funded school – non-selective	66	24
Independent or fee-paying school – bursary	4	1.46
Independent or fee-paying school – no bursary	9	3.28
Prefer not to say	1	0.36
Other (e.g. special schools for disabilities)	2	0.72
Household is current or previous recipients of income support (e.g. Universal Credit, Benefits)		
Yes	177	64.36
No	67	24.36
Prefer not to say	4	1.46
Don't know	27	9.82
Recipient of free school meals at any stage of schooling		
Yes	122	44.36
No	134	48.73
Prefer not to say	16	5.82
Don't know	3	1.09

Table 2.3

Motivations and barriers to applying to OXICPTR: themes and subthemes

Several themes emerged in the responses to two questions on the online survey. The questions focused on what (1) motivated and (2) deterred people from applying to OXICPTR for clinical psychology training; themes and statement examples can be seen below.

Survey question	Themes	Statement Examples*
Motivations to apply to OXICPTR	I like what the course can provide	"The course content and lecturers associated with the course." (P53, aspiring)
	It's close to home	"I was living in the Oxford area and had connections around there, knew a lot of the services in the area & therefore what placements were offered." (P146, non-Oxford trainee)
	I want to prove to myself and others	"Proving to everyone I can achieve at the highest level." (P113, Oxford trainee)
Barriers to applying to OXICPTR	The selection criteria work against my strengths	"My SE background means I didn't do as well academically in A-levels due to my environment/emotional and financial strain and so the points scoring system plays against me in this despite having lots of other strengths." (P47, aspiring)
	The city is too expensive	"…Oxford is very expensive to live in and doesn't have weighted pay to reflect this." (P9, non-Oxford trainee)
	I'll be the odd one out	"There is a whole belief about Oxford being full of posh, privileged people from private schools (and potentially Tories) that has put me off." (P35, aspiring)
	Never crossed my mind as a possibility	"…Coming from a low-income background, it isn't even considered to be an option." (P272, aspiring)

Note. P = participant no.; 'aspiring' = aspiring clinical psychologist; 'non-Oxford trainee' = trainee clinical psychologist not training in OXICPTR; 'Oxford trainee' = trainee clinical psychologist training in OXICPTR.

*Please see Appendix 2.3 for statement examples

Table 2.4

Practical and perceptual barriers to Clinical Psychology: themes and subthemes

Survey Question	Themes	Statement Examples*
Practical Barriers to Clinical Psychology	You can't be what you can't see	"I didn't go to a selective school, so didn't get that opportunity to speak to universities at outreach events, parents have no qualifications even between them so had no idea what an academic career even looks like, let alone something more vague like a psychology career." (P22, aspiring)
	Performance versus potential	"… I did not have a permanent home till I was 16 which led to me going to 5 different schools by the time I was in year 10. This made it hard to engage with studies." (P48, aspiring)
	It feels impossible to afford what it takes	"I had to work during my undergraduate to pay my rent. This stopped me from doing relevant volunteering…I had to work 2 years to save up to do a master's and I still had to do it part-time and worked full-time. I couldn't afford to relocate for jobs…I had to turn down assistant jobs because I would have been in too much debt trying to live off a band 4 salary." (P24, non-Oxford trainee)
Perceptual Barriers to Clinical Psychology	Am I late to the game?	"I didn't know a career in psychology existed until I was in my twenties…I couldn't catch up in terms of knowledge and experience. I often have thoughts that I'm not well-educated enough to pursue this career." (P66, aspiring)
	I don't fit the mould	"…I would often feel like a bit of an outsider or a bit, for want of a better word, "rough"…I often found myself making a joke about my hometown before anyone else did so that I wouldn't feel embarrassed… I worry about the impact of my regional accent when I start applying for DClinPsy courses next year." (P42, aspiring)
	I have to work twice as hard	"When you are from a working-class background, you can see that the profession assumes you are middle or upper class and to survive you have to

		work much harder, with fewer opportunities, more discrimination and assimilate to appearing middle/ upper class." (P183, non-Oxford trainee)
	The instability scares me	"Training is precarious and I debated going into a more steady career where I could earn money or risking psychology and potentially low-paid roles and not getting on the training." (P79, non-Oxford trainee)
	My background is a double-edged sword	"I think it can be positive by helping understand why those in lower SES backgrounds may not want to get help but it can also make you doubt yourself and think you're not good enough because you don't know fancy words or your accent/area your from may lead to judgement." (P30, aspiring)

Note. P = participant no.; 'aspiring' = aspiring clinical psychologist; 'non-Oxford trainee' = trainee clinical psychologist not training in OXICPTR; 'Oxford trainee' = trainee clinical psychologist training in OXICPTR.

*Please see Appendix 2.4 for more statement examples

Phase 3: Survey of Sixth-Form Students from Schools in Socio-Economically Disadvantaged Areas

Table 2.5

Demographic information of sixth-form respondents

Characteristic	n	%
Total respondents	32	
Age		
16	17	53.13
17	14	43.75
18	1	3.13
Year group		
12	26	81.25
13	6	18.75
Highest level of qualifications by respondents' parent(s) or guardian(s) by age of 18		
No formal qualifications	0	0.00
Qualifications below degree level	1	3.13
High school level qualifications	11	34.38
At least one degree qualification	14	43.75
Don't know	6	18.75
Prefer not to say	0	0.00
Other	0	0.00
Occupation of highest income earner in household		
Modern professional occupations	3	9.38
Clerical and intermediate occupations	0	0.00
Senior managers and administrators	6	18.75
Technical and craft occupations	4	12.50
Semi-routine manual and service occupations	5	15.63
Routine manual and service occupations	4	12.50
Middle or junior managers	1	3.13
Traditional professional occupations	1	3.13
Long term unemployed	2	6.25
Retired	0	0.00
Not applicable	0	0.00
Don't know	0	0.00
Prefer not to say	6	18.75
Type of school mainly attended between age 11-16		
State-run or state-funded school - selective on academic, faith or other grounds	7	21.88
State-run or state-funded school - non-selective	17	53.13
Independent or fee-paying school - bursary	1	3.13
Independent or fee-paying school - no bursary	5	15.63
Prefer not to say	2	6.25
Household are current or previous recipients of income support		
Yes	12	37.50
No	18	56.25
Prefer not to say	2	6.25
Don't know	0	0.00
Recipient of free school meals at any stage of schooling		
Yes	3	9.38
No	29	90.63

Survey Results

Of the 32 sixth-formers who responded, the majority (56%) had heard of clinical psychology. Only approximately a third of the respondents were ‘probably’ or ‘definitely’ considering a degree in Psychology at undergraduate level (34%). A large majority of respondents still preferred traditional face-to-face outreach to learn about Clinical Psychology (69%) with the preference for virtual outreach being substantially smaller (12%). As to what platform sixth-formers felt they were most likely to follow to attain outreach information from OXICPTR, the majority of the respondents chose they would follow Instagram (43%). The second largest majority was not interested in following at all (34%) and a small minority shared they would follow Twitter (6%) and the OXICPTR website (6%). In terms of workshop content, the most common interests (in order of popularity) were (1) the salary, progression and job prospects of psychologists, (2) what psychologists do, (3) what type of psychologists there are, and (4) a day in the life of a psychologist.

Discussion

The aim of this study was primarily to provide recommendations for OXICPTR to improve their outreach output, to widen participation in the course to those from disadvantaged SE backgrounds. This was done by focusing on four areas: (1) understanding whether those from low SE backgrounds were indeed underrepresented on the OXICPTR course and how this fared with national data, (2) understanding the barriers and motivations that drive aspiring/trainee clinical psychologists from disadvantaged backgrounds towards/away from applying to OXICPTR (3) understanding how their background may have affected their wider attitudes towards Clinical Psychology, and (4) attaining a clearer picture of what is needed of outreach from the first-hand perspectives of sixth form students.

(1) Are applicants and trainees of low SES underrepresented in OXICPTR, and how does this compare with national data?

What appears evident from the data is the overrepresentation of OXICPTR trainees and applicants from higher SE quintiles and the underrepresentation of those from lower SE quintiles between 2015-2020. There were 5.6 times more applicants and 7.8 times more acceptances to OXICPTR from Quintile 5 compared to Quintile 1 over the 5 years. To note, the proportions of success rates of those from different socio-economic quintiles did not differ significantly once applicants passed the selection process. This may suggest that should OXCIPTR desire to increase the representation of trainees from socio-economically disadvantaged backgrounds in their training programme, interventions should be undertaken to address the barriers and deterrents of applying to the course and at an early stage in a student's career journey.

(2) What are the barriers and motivations to applying to OXICPTR?

Given the underrepresentation of those from lower SE quintiles in the OXICPTR applicant pool which subsequently affected the representation in the trainee cohorts,

understanding the reasons that encourage or discourage potential or ex-applicants may help the OXICPTR outreach team remediate the barriers and/or enhance the appealing qualities of the course. From the qualitative survey of 275 aspiring and trainee clinical psychologists self-identifying as from a low SE background, the majority (67%) reported not having historically applied, or did not plan to apply, to the OXICPTR course. The opportunity in this study to explore what deterred these aspiring psychologists from OXICPTR can potentially point OXICPTR to areas of improvement.

In terms of barriers, a majority reported fearing ‘risking an application’ to an institution that they felt would most likely reject them. Many cited that their academic grades did not reflect their potential, and with OXICPTR’s selection process prioritising scholastic achievements, they felt that their application would be at a disadvantage. Applicants also noted that the choice of not applying to OXICPTR is further reinforced by the course’s lack of systematic consideration of contextual barriers to academic success, as illustrated by its widely publicised scoring system. However, this is nuanced as a sizeable proportion also feared a tokenistic, ‘pity’ acceptance should the course utilise contextual admission processes. Additionally, there were deeply ingrained stereotypes of ‘Oxford’ (as both a city and an institution) that seemed to dissuade many from applying. From the responses, it appeared that the perception of OXICPTR is inextricably entangled with the stereotypes of Oxford as an institution and city. The adjectives ‘posh’, ‘elite’, ‘classist’ and ‘racist’ often frequented the responses around why one chose not to apply to the course. Many envision that should they ‘get in’, their time in Oxford may not only be financially costly but also emotionally taxing, fuelled by feelings of isolation from a predominantly middle-class cohort and a middle-class city. This fear of isolation, or feeling of ‘otherness’, stretched beyond differences in socio-economic status per se. To respondents, this ‘otherness’ came from a wide range of other signifiers of class, feeling concerned that they would not be able to

integrate due to their accents, manners of speaking, appearance, lifestyle, cultural interests, political opinions, and more. To note, based on admissions data over 5 years, these stereotypes may not be unfounded given the large representation of trainees from the highest socioeconomic bracket. However, many reported simply ‘not seeing myself there’, so perhaps rather than due to a fear of being othered once one is accepted, cultural influences as a result of coming from a different background may contribute to a narrative that dissuades applicants from different economic backgrounds from even wanting to apply in the first place. On the contrary, it is also because of the stereotypes of Oxford that a minority of respondents felt more encouraged to apply to OXICPTR – in being accepted by what feels exclusive, some felt empowered to prove to themselves and others that they have achieved what is perceived as a hallmark of success through the connotations of ‘Oxford’. Beyond this, most of the motivations for applying to OXICPTR were practical reasons including proximity to home and the accreditations and opportunities provided through training at OXICPTR.

(3) How does one’s socioeconomic background impact the pursuit of clinical psychology, from the perspective of aspiring or trainee clinical psychologists?

Meaningful changes to OXICPTR selection processes and outreach output can be supported through understanding the lived experiences of socio-economic-related barriers applicants face in their pursuit of a career in clinical psychology. From the qualitative survey of aspiring and trainee clinical psychologists, the main practical barriers identified included (i) a lack of exposure and support to higher education and/or clinical psychology from a young age, (ii) socio-economic related stressors that affect one’s ability to attain optimal grades (e.g. carer responsibilities, single parenthood, leaving education early, working whilst studying full-time), (iii) inability to afford to work in underpaid/unpaid pre-qualified jobs or invest in qualifications that may open doors to more lucrative pre-qualification experiences. These practical barriers seem to be inextricably linked to the perceptions one develops of

themselves and their relationship with the field. In the responses, mentions of practical barriers are often coupled with experiences of self-doubt around one's competencies, concerns around whether one is at a disadvantage compared to their middle-class peers, the stress of feeling like one has to work twice as hard due to one's background, and constant doubt around whether one should have chosen a more stable career. For many, feeling isolated in 'a middle-class profession' becomes at the experiential forefront in their interactions with the field - to some, it gave them pride and motivation to change the landscape of clinical psychology; to others, it increased one's self-consciousness and self-doubt. Many felt that in pursuing clinical psychology, they may have dislodged from their working-class roots yet not fully integrated or accepted into the middle class that predominates the field. As a result, many shared feelings of becoming wedged between (or cast as an outsider) both groups. In sum, many respondents' experiences in their upbringing and journey seem to shape personal and collective narratives around not being the right 'fit' for clinical psychology.

(4) What do sixth-form students, self-identifying as from a low SE background, need from outreach teams?

Contrary to the responses from many aspiring/trainee clinical psychologists who shared that they were not aware of clinical psychology as a career path during their school years, the majority of sixth-form respondents reported that they were aware of clinical psychology. However, a substantial proportion of these respondents, most of whom were recruited through Psychology A-level classes, were not interested in pursuing psychology or clinical psychology. Therefore, OXICPTR needs to be mindful that whilst face-to-face outreach workshops were preferred by sixth-form students, these workshops may only be targeting a small minority of those interested in the career path. With only one to two workshops occurring annually, the reach of these workshops may thus be very limited. Secondly, whilst

most information on OXICPT is shared on Twitter and the OXICPTR website, these platforms are the least popular for sixth-form respondents. Based on our findings, to reach the relevant sixth-form students, OXICPTR should consider expanding into other online platforms like Instagram which was the most preferred medium to follow based on the current survey. Lastly, sixth-form respondents were interested in knowing the salary, progression and job prospects of clinical psychologists, what clinical psychologists do and alternative types of psychologists.

(5) In light of findings from Questions 1-4, what recommendations can be made to improve the underrepresentation of those from low SES backgrounds and outreach activity output by OXICPTR?

Based on qualitative and quantitative results from aspiring/trainee clinical psychologists as well as sixth-form students who self-identify as from a socio-economically disadvantaged background, some actionable recommendations for the OXICPTR outreach team are presented below. Many of the recommendations echo those provided by the Position Statement published by ClassClin (Goddard et al., 2021)

Table 2.6

Recommendations for OXICPTR

Content	• Sixth-formers are most interested in the salary, progression and job prospects of clinical psychologists, what clinical psychologists do and alternative types of psychologists. • Debunk myths and stereotypes of Oxford and what actions OXICPTR are doing to address representation issues. • Invite staff and trainees from diverse backgrounds to share their varied upbringing, accents, and journeys on the course through videos or workshops.
Medium	• Face-to-face outreach is still preferred by most sixth-formers, however, OXICPTR needs to consider whether this is sustainable and effective given its limited reach. Alternative ways to reach those interested should be considered (e.g. social media). • Information-giving platforms may be subject to change based on the trends of each generation. Therefore regular feedback should be sought as to which mode of communication is the most effective. As of 2022, a focus on Instagram rather than Twitter or OXICPTR websites may be more effective to engage sixth-form students.
Systemic	• Based on Standards for the accreditation of Doctorate programmes in Clinical Psychology (2019), transparent and public records are required on what OXICPTR are doing to address representation issues e.g. mentorship, outreach, bursaries, and support that is offered to encourage more people from diverse backgrounds to apply. • Contextual selections should be explored further given the underrepresentation of applicants and trainees from low SE backgrounds may be due to OXICPTR's academically focused selection criteria and limited systematic considerations of contextual barriers. However, this discussion must be balanced with opposing opinions (i.e. fear of tokenistic acceptance) which may cause a double bind. • Create mentoring systems that help individuals from disadvantaged socio-economic backgrounds who do not have the financial or social capital to connect with those within the field. • Consistency of outreach output needs to be discussed. There was limited documented activity internally and externally despite Standards for the accreditation of Doctorate programmes in Clinical Psychology stating it as a requirement for all courses.

Feedback from the OXICPTR Outreach team

Feedback on the findings and recommendations were sought with the Outreach deputy lead (RV) on May 26th 2022 and the Outreach lead (CB) on May 30th 2022. The main discussion points were:

- An agreement that OXICPTR is inextricably linked with the stereotypes and 'brand' of Oxford as an institution and as a city. There was a reflection that that something should be done through outreach to clarify and/or debunk some of these conceptions.
- An agreement that outreach work is hard for trainees and internal course staff to undertake on top of the pre-existing demands of other job responsibilities. Ideally, someone could be hired on a part-time basis to undertake outreach demands.
- Agreement that documentation internally and externally of outreach activity in OXICPTR has been poor and this adversely affects the amount of work required to do for outreach volunteers each year.
- Agreement that the cost of conducting face-to-face outreach is high and efforts to maximise the reach of outreach efforts through other means should be considered.
- Discussion around the difficulties of doing contextual admissions 'properly' as well as the limitations of tokenistic acceptances. More discussions are required around this area given existing discussions have been informal and limited.

Limitations

Information on intersectional characteristics and their relation to socioeconomic status was limited in this investigation. This was partly due to the limitations of publicised data (i.e. no publicised information on how POLAR quintiles intersect with other identity characteristics) but also due to the breadth of the current project which came at the cost of depth. Currently, peer-reviewed research on class, socioeconomic status and clinical

psychology is scarce if not non-existent. A systematic evaluation of the recommendations provided by this study will be required in the future.

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Theory Driven Research Project

Examining the relationship between gender identity, psychological processes and social anxiety in a transgender clinical sample

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Abstract

Aim: There is currently limited understanding of the nature and prevalence of social anxiety disorder in transgender populations. The aim of the study was to examine the prevalence of social anxiety in a transgender sample and examine whether there were any gender identity differences in various psychological processes hypothesised to correlate with social anxiety.

Method: The current study was split into two phases. In the first phase, 251 cisgender participants were compared with 161 transgender participants on the Social Phobia Inventory (SPIN). In the second phase, 120 transgender participants from the first phase completed further measures related to cognitive-behavioural and transgender minority stress-related processes hypothesised to underlie social anxiety.

Results: Compared to cisgender males, cisgender females and transgender females, transgender males were found to have elevated social anxiety scores on the SPIN. There were no differences in cognitive behavioural measures and transgender minority stress-related measures between transgender males and females. Significant associations between cognitive and behavioural processes and social anxiety levels were found. The additional contribution of minority stress measures on predicting the level of social anxiety was smaller but significant.

Discussion: Implications of these findings on the applicability of established cognitive-behavioural models on transgender experiences of social anxiety, as well as limitations of the current study, were discussed.

Keywords: *transgender mental health, social anxiety, minority stress*

Examining the relationship between gender identity, psychological processes and social anxiety in a transgender clinical sample

Introduction

Social anxiety disorder (SAD) is an anxiety disorder in which individuals typically fear scrutiny and negative judgements from others, and fear acting in an embarrassing and humiliating way (5th ed.; DSM-5, American Psychiatric Association, 2013). It is extremely common, with a lifetime prevalence rate of 13.3% (Kessler, 1994). It has been suggested that those who have experienced greater scrutiny and negative judgment in the past may be particularly prone to experiencing social anxiety (e.g. McCabe, 2003). However, very little is known about how the experience of social anxiety translates to the transgender population, even though scrutiny by others is a particularly likely source of psychological distress for this group as a result of historical and residual marginalisation and stigmatisation of this community (Sánchez & Vilain, 2009).

Prevalence of SAD in transgender people

Very little is known about whether the prevalence rates differ in transgender populations compared to cisgender counterparts. In a study conducted in a clinical setting, Bergero-Miguel et al. (2016) found that 31.4% of transgender individuals interviewed with the Mini-International Neuropsychiatric Interview (MINI) met the diagnostic cut-off for SAD. It is possible that the prevalence rates of SAD in the transgender population may be heightened relative to the general population due to an increased risk of exposure to adverse life events, which is a major risk factor suggested to predict levels of social anxiety (Aune & Stiles, 2009; Ranta et al., 2012; Roth et al., 2002). For example, McCabe et al (2003) found that more individuals with SAD reported historical bullying and teasing than those with Obsessive Compulsive Disorder or Panic Disorder. Though it is unlikely that a single mechanism accounts for the development of SAD (Brook & Schmidt, 2008), we hypothesise that because transgender individuals are at a heightened risk of being a target for

discrimination, ostracization and rejection (Bradford et al., 2013; Grant et al., 2010; Lombardi et al., 2002), this may increase their risk of developing SAD compared to the general population.

Gender differences in SAD in transgender people

Whilst gender differences in the occurrence, development and presentation of SAD are extensively studied in the general population (Asher et al., 2017), most of these studies have been conducted on cis-gendered participants. Such studies largely indicate that women have higher prevalence rates of SAD than men (Kessler, 1994; Ohayon & Schatzberg, 2010; Xu et al., 2012). However, very little is known as to whether there are any gender differences in SAD in transgender groups.

Preliminary findings around gender differences in SAD in transgender groups have been mixed. Ho & Mussap (2020) found that transgender males had significantly higher levels of social anxiety on the Liebowitz Social Anxiety Scale (LSAS; Heimberg et al., 1999). The same was found on their adapted scale, the Transgender Social Anxiety Scale (TSAS), which measured levels of avoidance and fear in trans-specific social situations. In other studies, gender sub-group differences in SAD were found to be non-significant (Bergero-Miguel et al., 2016; Gómez-Gil et al., 2008).

It has been suggested that transgender women may be more susceptible to SAD than transgender men, as gender non-conformity to societal expectations of a male as a male-assigned-at-birth has been found to be less socially acceptable than gender non-conformity to expectations of females as a female-assigned-at-birth (Skidmore et al., 2006). In line with this, gender non-conformity is associated with higher levels of distress in gay or heterosexual men than lesbian or heterosexual women (Lippa, 2008). It is also harder for transgender females to be perceived as their identified gender (i.e. “passing”) than transgender males

(Roen, 2002). Transgender females seek therapy more often than transgender males as they often do not experience adequate voice changes (Hancock et al., 2014) likely due to differences in the efficacy of masculinising and feminising hormones (Pfafflin & Junge, 2003). Research suggests transgender females receive less social, familial and romantic support than transgender males (Kockott & Fahrner, 1988), factors which are protective against SAD (Porter & Chambless, 2017).

Perhaps as a result of these difficulties faced in trying to conform to cis-normative gender expectations, transgender women experience more gender-based discrimination and verbal and physical assaults than transgender men (Nuttbrock et al., 2012; Sterzing et al., 2017; Testa, Habarth, Peta, et al., 2015; Wallien et al., 2010). Given people with SAD have higher standards of social performance and fear of negative evaluation (Wells et al., 1995) as well as higher levels of motivation to be socially acceptable (Feng et al., 2018), we hypothesised that more barriers for transgender females to conform to cis-gender norms may increase their vulnerability to SAD than transgender males.

Cognitive-behavioural maintenance factors of SAD in transgender groups

Within the cognitive framework of SAD (Clark & Wells, 1995), SAD is maintained by excessive self-focused attention around how one is perceived (Goldfried et al., 1984; Hope & Heimberg, 1988), overdependence on internal cues (i.e. emotions or imagery) as evidence for their social performance, and fear and avoidance of social situations where one could be subjected to negative evaluation (Heeren & McNally, 2017). Whilst studies on transgender groups often conceptualise the relationship between chronic exposure to enacted discrimination, internalising processes and increased subsequent psychological distress from a minority stress framework (Meyer, 2003; Testa, Habarth, Peta, et al., 2015), some have argued that these internalising processes show strong similarities with maintenance factors

described in cognitive-behavioural frameworks of SAD (Meidlinger & Hope, 2014). Since cognitive behavioural therapy (CBT) is currently the first-line psychological treatment for SAD (NICE, 2004), it is important to examine whether the cognitive model of Clark & Wells (1995) applies to transgender groups. The present study aimed to examine whether cognitive and behavioural processes proposed by Clark and Wells (1995) are associated to the level of SAD in transgender individuals.

Gender minority stress and SAD

SAD is one of several possible consequences of the stressful nature of belonging to a minoritised group. From a minority stress perspective (Meyer, 2003), individuals with a minority status present with higher levels of mental and physical health difficulties not only as a result of distal stressors (i.e. objective, enacted experiences of stigma and discrimination) but also as a result of proximal stressors (i.e. internalised and subjective negative appraisals of the self as a result of chronic exposure to societal rejection). For example, Ramirez & Galupo (2019) found a predictive role of distal and proximal stressors in lesbian, gay and bisexual people of colour, with proximal stressors accounting for 15% more variance of anxiety and depression than distal stressors alone, and 33% when combining the effect of proximal and distal stressors.

A trans-specific development of the minority stress model (Testa et al., 2015) posited three proximal stressors as moderating and mediating the relationship between distal stressors and mental health, viz: (i) internalised transphobia, (ii) negative expectations and (iii) concealment. This model proposes that cis-normative gender norms and transphobic narratives are internalised and form negative beliefs about one's identity and place in society (Bockting et al., 2013). Transgender individuals engage in the concealment of transgender identity or/and desire to "pass" by conforming to binary gender norms (Bockting et al.,

2013), experience guilt and shame about their transgender identity (Schaefer & Wheeler, 2004) and avoid other transgender individuals (Hendricks & Testa, 2012). These responses and coping mechanisms can contribute to further psychological distress (Bockting et al., 2013; Bry et al., 2018; Rood et al., 2017). Transgender-specific proximal stressors have been found to contribute to depressive symptoms independent of distal stressors, even when controlling for age, gender and occupational status (Jäggi et al., 2018). The current study additionally explored whether and to what extent trans-specific proximal stressors are associated with the level of SAD in transgender individuals.

The present study, therefore, aims to examine the frequency of SAD in transgender compared to cisgender participants, and secondly to examine whether the cognitive model and proximal stressors account for SAD risk in transgender people and whether this differs between gender identity groups.

Hypotheses

Phase 1

H1: The level of SAD symptoms in the transgender group will be significantly higher than the cisgender group and the level of SAD will be higher in transgender females than males.

Phase 2

In the transgender samples:

H1: There will be gender identity differences in fear and avoidance, and cognitive and behavioural processes involved in social anxiety disorder.

H2: There will be gender identity differences in internalised transphobia, negative expectations and non-disclosure.

H3: There will be a significant association between the level of social anxiety and cognitive and behavioural processes involved in social anxiety disorder and further associations will be found with proximal stressors.

Method

Procedure

The current study utilised a cross-sectional design where participants were invited to complete an anonymous survey online. Transgender participants were recruited through a national NHS Gender Identity Service. Cisgender participants were recruited online via social media between January 2022 and January 2023.

The online survey included two phases. The first phase included simple demographics and a social anxiety measure. Measures were kept to a minimum in this section, aimed at maximising uptake to address our first research question on the occurrence of SAD in transgender individuals. This section then provided a pool for recruitment to the more extensive second phase of the survey, which focused on the psychological processes of SAD in the transgender group specifically. A set of questionnaires were chosen to evaluate the extent of group differences and similarities between transgender women and men in the established cognitive and behavioural processes in SAD alongside measures of trans-specific social anxiety and proximal stressors. A set of unpublished and unvalidated questionnaires (Social Attitudes Questionnaire [SAQ], Social Behaviour Questionnaire [SBQ] and Social Cognitions [SCQ] by Clark (2005) were chosen as they were deemed the best representative of the internal processes that maintained social anxiety within the cognitive-behavioural model of social anxiety (Clark and Wells, 1995) that was being explored.

Sample

As there was no previous study to base our effect sizes on *a-priori,* power analysis for the group comparison was based on whether we could detect a clinically reliable difference between the two groups. We expected a small to moderate effect size in our sample. Using G*Power we found that for the first phase, the sample size for a two-tailed one-way ANOVA for four groups at a power level of 0.8, effect size of 0.3, and a sample of 128 in total were

required. For the second phase, we found that a minimum of 120 participants were needed for independent t-tests between two groups at a power level of 0.9 and an effect size of 0.6.

Inclusion Criteria (transgender group)

- Identified as transgender (transgender male or female).
- Was accessing an NHS Gender Identity Service
- Over the age of 18, had access to the internet, and had the capacity to consent.
- Was able to read English and provide informed consent to participate in the study

Exclusion Criteria (transgender group)

Identified as any other gender other than transgender male or female (e.g. non-binary)*Inclusion Criteria (cis-gender group)*

- Identified as cis-gender (male or female)
- Over the age of 18, had access to the internet, had capacity to consent.
- Was able to read English and provide informed consent to participate in the study

Exclusion Criteria (cis-gender group)

- Identified as any other gender other than cis-gender male or female

Measures

Cognitive-behavioural measures

Social Phobia Inventory (SPIN; Connor et al., 2000). The SPIN is a 17-item self-report questionnaire that screens and measures the severity of SAD, with a clinical cut-off score of 19. The SPIN has demonstrated good test-retest reliability, internal consistency ($\alpha = 0.94$), convergent and divergent validity (Connor et al., 2000). The internal consistency in the present sample for the total SPIN score was $\alpha = 0.948$. and 0.873, 0.897 and 0.829 for fear, avoidance and physiological symptom subscales respectively. Please see Appendix 3.3 for the full questionnaire.

Social Attitudes Questionnaire (SAQ; Clark, 2005). The SAQ is an unpublished 50-item self-reported measure assessing common beliefs about the self and social interactions. Ratings range from 1 (totally disagree) to 7 (totally agree). The internal consistency of the current sample was α = 0.945. Please see Appendix 3.4 for the full questionnaire.

Social Behaviour Questionnaire (SBQ, Clark, 2005) is an unpublished 29-item self-reported measure assessing how often individuals use common safety-seeking behaviours in anxiety-provoking social situations. The frequency with which each behaviour is used in social situations is rated from 0 (never) to 3 (always). The internal consistency of the current sample was α = 0.891. Please see Appendix 3.5 for the full questionnaire.

Social Cognitions Questionnaire (SCQ, Clark, 2005). The SCQ is an unpublished 22-item self-reported measure assessing the frequency and level of belief of negative automatic thoughts in social anxiety provoking situations in the past week. The mean of frequency subscale ratings ranges from 1 to 5. The internal consistency of the current sample was α = 0.954. Please see Appendix 3.6 for the full questionnaire.

Trans-specific measures

Transgender Social Anxiety Scale (TSAS; Ho & Mussap, 2020). The TSAS is a 15-item measure used to assess the level of social anxiety of transgender individuals in social situations, based on the more commonly used SAD measure Liebowitz Social Anxiety Scale (LSAS), scored on a 4-point Likert-scale from 1 (none) to 4 (severe), on a 2 x 4 indices (i.e. fear and avoidance independently in the four situations). It has been shown to have good internal consistency, construct and discriminant validity in a community sample (Ho & Mussap, 2020). The internal consistency on the TSAS fear total score of the current sample was α = 0.939, and good internal consistency was found in the subscales (social = 0.816, public = 0.797, organisational = 0.861 and religious = 0.923). The internal consistency was

strong on the TSAS avoidance total score (α = 0.958) and its subscales (social = 0.902, public = 0.781, organisational = 0.913 and religious = 0.941). It was not possible to obtain consent to provide the TSAS from the original authors.

Transgender Identity Survey (TIS; Bockting et al., 2020). The TIS is a 26-item scale used to measure internalised transphobia. It is scored on a 7-point Likert scale from Strongly Disagree (1) to Strongly Agree (7). The TIS is split into four subscales; (1) Pride; "a positive affective reaction to one's transgender identity", which was reverse scored, (2) Passing; "an overemphasis on passing…reflecting internalised stigma attached to gender nonconformity", (3) Alienation; "feeling different from, and embarrassed by, other transgender individuals", and (4) Shame; "feeling defective or not belonging…the most direct manifestation of internalising society's normative gender expectations and the social stigma attached to nonconformity" (Bockting et al., 2020). The total scale has been shown to have excellent internal consistency (α = 0.90). The internal consistency of the total score in the current sample was excellent (α = 0.935) and subscales ranged from good to excellent internal consistency (Pride=0.89, Passing=0.90, Alienation=0.63, and Shame=0.898). Please see Appendix 3.7 for the full questionnaire.

Gender Minority Stress and Resilience Scale (GMSR; Testa, Habarth, Peta, et al., 2015). The GMSR assesses 9 constructs of distal and proximal stress and resilience factors in transgender populations. The scale has good model fit, criterion validity, convergent validity, and discriminant validity (Testa, Habarth, Balsam, et al., 2015). Two constructs of interest were used in this study.

- **Negative expectations.** 9 items on a 5-point Likert scale were used to measure negative expectations for rejection among sexual minorities (Goldblum, Waelde, Skinta, & Dilley, unpublished manuscript; see Testa et al, 2015 for more details). Responses ranged from

strongly disagree (0) to strongly agree (4). The internal consistency of the current sample was α = 0.888.

- **Non-disclosure/Concealment.** 5 items on a 5-point Likert scale were used to assess means of non-disclosure of transgender identity utilized by transgender people as a result of discomfort or fear of being identified as transgender (Testa, Habarth, Peta, et al., 2015). The internal consistency of the current sample was α = 0.849.

Please see Appendix 3.8 for the questionnaire on negative expectations and non-disclosure.

Data analytic strategy

Data cleaning and analyses were performed using IBM SPSS Statistics for Windows, Version 28.0 (IBM Corp, Armonk, NY, USA). The overall response times of all participants were checked and there were no significant outliers in the time taken to complete the questionnaire. Five participants from the transgender group were removed from the analysis as they did not fulfil the gender identity inclusion criteria, i.e. identified their gender identity as transgender female or male (e.g. non-binary, those who have de-transitioned). Normal distribution was confirmed through visual inspection of histograms and with the Kolmogorov-Smirov test for all groups. Levene's test of homogeneity was examined for all between-subject t-tests and ANOVAs conducted. Bonferroni corrections were used as appropriate. Where significant interactions of main effects were found in ANOVA tests, either Fisher LSD or Dunnett's T3 test were used based on the Levene test. For within-subject comparisons, Mauchley's test of sphericity was used and if the assumption of sphericity was rejected, Greenhouse Geiser was used.

To examine whether there were any differences in the level of social anxiety between cisgender and transgender groups, a one-way between-subject ANOVA was conducted, with gender identity groups as the independent variable and SPIN total score as the dependent

variable. For subscales, a mixed model ANOVA was used. If main interaction effects were found, post-hoc tests were used to examine the interactions further. To examine whether there were any gender identity differences between cognitive and behavioural processes and proximal stressors, one-way t-tests were conducted for all scales. For scales that had subscales, a mixed model ANOVA was used. Lastly, a multiple hierarchal linear regression was run to predict social anxiety levels on the SPIN from cognitive and behavioural processes underlying SAD, internalised phobia factors and gender. The first block included cognitive-behavioural processes (SAQ, SBQ, SCQ), the second block included the addition of internalised transphobia measures (TIS, NE, ND), and the third block included the dummy variable of gender.

Ethical considerations

Ethical approval was sought and attained (Ethics no.: 300471, see Appendix 3.2 for a Copy of Ethical Approval) from the Health Research Authority (HRA) and Health Care Research Wales (HCRW). Informed consent was obtained for all participants.

Patient and Public Involvement (PPI)

The study was developed with a Patient and Public Involvement (PPI) group in a national NHS Gender Identity Service with transgender people, and feedback was used to inform the research design. It was reviewed by them on three occasions: the initial proposal; the development of the questionnaires; and the final study protocol prior to launching. The PPI group found the study questions and aims highly relevant and impactful for their community, and their guidance informed robust demographic questions and the appropriateness of the psychometric measures.

Results

Descriptive data

Participants

In Phase 1, 416 respondents completed the questionnaire. 66 identified as a transgender female, 95 as a transgender male, 226 as a cisgender female and 25 as a cisgender male. In Phase 2, 52 transgender females and 68 transgender males completed the questionnaire. Descriptive statistics for demographic and clinical variables separated by cisgender and transgender groups are shown in Table 3.1 and Table 3.2.

Table 3.1

Demographic characteristics

	Cisgender (n=251)		Transgender (n=161)	
	Frequency	Percentage	Frequency	Percentage
Total	251	100	161	100
Gender identity				
Female	226	90	66	41
Male	25	10	95	59
Age group				
18-24	74	29.5	69	42.9
25-39	174	69.3	54	33.5
40-60	3	1.2	21	13
60+	0	0	17	10.6
Ethnicity				
White	157	62.5	145	90.1
Asian	29	11.6	2	1.2
Black	3	1.2	2	1.2
Mixed	53	21.1	0	0
Other	9	3.6	12	7.5
Sexuality				
Heterosexual	175	69.7	36	22.4
Homosexual	17	6.8	29	18
Bisexual	43	17.1	43	26.7
Asexual	3	1.2	14	8.7
Other	13	5.2	39	24.2
Socio-economic status				
Semi- or unskilled manual	4	1.6	8	5
Skilled manual	8	3.2	17	10.6
Lower managerial/administrative/professional	110	43.8	42	26.1
Intermediate managerial	62	24.7	31	19.3
Higher managerial	25	10	14	8.7
Student	33	13.1	14	8.7
Unemployed – homemaker, unpaid	2	0.8	22	13.7

carer, retired, sick				
Other	7	2.8	13	8.1

Table 3.2

Gender-affirmative medical procedures (GAMI) characteristics (of transgender group)

	Frequency	Percentage (%)
GAMI that has been completed		
Hormones	149	92.5
Top/bottom surgery	74	46
Completed all desired medical procedures	11	6.8
None/no interest	1	0.6
Other	11	19.8
GAMI that is desired but not completed		
Hormones	26	16.1
Top/bottom surgery	92	57.1
Not sure	28	17.4
Both – Hormones and top/bottom surgery	20	12.4
None/no interest	8	5.9
Other	31	19.3
GAMI – source		
Private	67	41.6
NHS	140	87
Online	8	5
Other	11	6.8

Main analyses

Phase 1

A one-way ANOVA was conducted with four gender identity groups as the independent variable (cisgender male and female, transgender male and female) and SPIN scores as the dependent variable. Homogeneity of variance was assumed based on Levene's test. There was a significant main effect of group for the mean SPIN score ($F)_{(3,408)}$= 11.241, p < 0.01); Fisher's LSD test found no significant differences between cisgender males, females

and transgender females, which all scored significantly lower than the transgender male group ($p < 0.05$; Table 3).

For the subscale analyses for the SPIN, a mixed model ANOVA was used. Mauchly's tests of sphericity was significant and therefore Greenhouse Geisser was used for within-subject variables. The main effect of subscale was significant $(F)_{(1.53, 243.51)}=310.665$, $p <.001$) as was the main effect of gender identity $(F)_{(1,159)}=8.984$, $p <.003$). These effects were modified by a significant interaction between gender identity group and SPIN subscale $(F)_{(6,816)}=9.90$, $p <.001$). Simple main effects analysis showed that gender identity had a significant effect on fear subscales $(F)_{(3,408)}=9.459$, $p <.001$), on avoidance subscales $(F)_{(3,408)}=14.41$, $p <.001$) and physiological subscales $(F)_{(3,408)}=4.38$, $p <.005$).

Levene's test was not significant for avoidance and physiological symptoms, therefore Fisher LSD was used. Levene's test was significant for the fear subscale, therefore Dunnett T3 was used. For fear and avoidance subscales, transgender males were significantly different to all three of the other groups ($p < 0.05$). For physiological subscales, transgender males were significantly different to transgender females and cisgender females ($p < 0.05$) but not cisgender males.

Table 3.3

SPIN scores by group

	Total Mean (SD)	Cisgender female Mean (SD)	Cisgender male Mean (SD)	Transgender female Mean (SD)	Transgender male Mean (SD)
SPIN Total	29.34 (15.44)	26.34 [a] (13.89)	28.44 [a] (13.87)	29.05 [a] (16.71)	36.89 [b] (16.08)
SPIN Fear	11.18 (5.57)	10.23 [a] (5.03)	10.76 [a] (4.34)	10.92 [a] (6.02)	13.73 [b] (6.04)
SPIN Avoidance	12.4 (7.04)	10.76 [a] (6.34)	11.72 [a] (6.39)	12.9 [a] (7.44)	16.12 [b] (7.14)
SPIN Physiological	5.76 (4.12)	5.35 [a] (3.81)	5.96 (4.58) [ab]	5.18 [a] (4.42)	7.05 [b] (4.30)
Means that share a superscript are not significantly different from each other (p<0.05)					

Phase 2

Of the 161 transgender respondents from Phase 1, 120 (52 transgender females and 68 transgender males) completed Phase 2 of the survey. An independent samples t-test comparing participants who completed only Phase 1 compared to those who completed both phases found that there were no significant differences in SPIN total scores, $t_{(159)} = .617$, $p = .538$.

A mixed-model ANOVA was conducted to investigate whether there were differences in SPIN total scores between gender and completion status (Phase 1 and 2 versus only 1). There was a significant main effect of gender ($F_{(1, 157)}=10.896$, $p <.001$) but no significant main effect of completion status ($F_{(1, 157)}=0.001$, $p <.976$). There were no significant interaction effects between gender and completion status on SPIN total scores ($F_{(1, 157)}=2.219$, $p <.138$).

Cognitive-behavioural processes: SAQ, SBQ, SCQ

To examine whether there were differences between cognitive and behavioural processes proposed to underlie SAD between transgender males and females, a mixed model ANOVA was conducted on the mean scores of SAQ, SBQ and SCQ. Mauchly's Test of Sphericity was significant, therefore the Greenhouse-Geisser corrections were used. There was a significant main effect of the subscale $(F)_{(1.147,135.373)} = 144.830$, $p < .001$) and there was a significant main effect of gender on scores $(F)_{(1,118)} = 1.946$, $p <.016$). There were no

significant interaction effects between cognitive and behavioural processes with gender identity $(F)_{(1.147)} = .072$, $p < .072$).

Proximal stressors: TSAS

A mixed model ANOVA was conducted for the TSAS subscales. The main effect of subscale on TSAS subscale scores was significant $(F)_{(1,117)} = 14.966$, $p < .001$) but the main effect of gender identity on TSAS subscale scores was not significant $(F)_{(1,117)} = .007$, $p = .934$). The interaction effects between the TSAS subscale and gender identity groups did not reach significance $(F)_{(1,117)} = .214$, $p = .645$).

Proximal stressors: TIS

A mixed model ANOVA was used to examine the four subscales (pride, passing, alienation and shame). Mauchly's Test of Sphericity showed that the assumption of sphericity was significant ($p < .001$) therefore the Greenhouse-Geisser correction was used to correct for this. The main effect of subscales on subscale scores was significant $(F)_{(1.389,162.899)} = 1370.78$, $p < .001$) but the main effect of gender was not significant $(F)_{(1,118)} = .729$, $p = .395$). Interactions between TIS subscales and gender did not reach significance $(F)_{(1.380,162.899)} = .950$, $p = .359$).

Proximal stressors: NE + ND

Levene's test showed that homogeneity of variance assumptions was met for both scales. Independent t-tests showed that there were no significant differences between gender identity groups in negative expectations $t(117) = 1.294$, $p = .198$ and non-disclosure $t(118) = 1.394$, $p = .166$, between transgender males and females.

Table 3.4 summarises the mean and standard deviation of the cognitive and behavioural measures between transgender males and females.

Table 3.4

Cognitive-behavioural and proximal stressors outcomes of transgender males and females

Measure	Transgender female Mean (SD)	Transgender male Mean (SD)
Cognitive-behavioural measures		
SAQ	188.25 (61.16)	194.63 (50.67)
SBQ	43.2 (16.00)	44.04 (12.42)
SCQ	59.25 (23.61)	60.40 (19.72)
TSAS Total	60.31 (30.55)	60.71 (20.84)
TSAS Fear	31.76 (14.69)	31.68 (10.46)
TSAS Avoidance	28.55 (16.75)	29.09 (11.90)
Proximal stressors		
TIS Total	120.21 (29.77)	114.88 (31.73)
TIS Pride	35.33 (10.41)	35.69 (11.42)
TIS Passing	35.31 (9.65)	33.18 (11.55)
TIS Alienation	13.65 (4.30)	12.65 (4.64)
TIS Shame	35.92 (12.58)	33.37 (11.75)
NE	22.65 (9.08)	20.68 (7.52)
ND	19.44 (5.34)	18.06 (5.42)

Association between psychological factors and social anxiety scores

A hierarchical linear multiple regression was run to examine the associations between social anxiety levels on the SPIN and hypothesised associated factors, that is, cognitive and behavioural processes, internalised phobia factors and gender independent variables. The overall regression model revealed that the independent variables significantly predicted SPIN scores ($F_{(8, 111)}$=49.083, p <.001, $R^2_{Adjusted}$=.675).

The hierarchal multiple regression revealed that at Step 1, socially anxious behaviours and social anxiety cognitions significantly contributed to the regression model, F(3,116)= 68.959, p <.001, $R^2_{Adjusted}$ = .641. Both socially anxious behaviours and socially anxious

cognitions were significantly associated with social anxiety levels (β = -.478, t = -3.955, p < .001 and β =.265, t = 2.846, p = 0.005). At Step 2 (F(7,112) = 33.293, p < .001, $R^2_{Adjusted}$ = .675) where proximal stressors were included, there was a small but significant change (R^2 Change = .035), with internalised transphobia related to the desire to pass significantly contributing to the model (β = -.295, t =-2.692, p = .008). In the final model, there was again a small but significant change with the addition of proximal stressors and gender variables ((R^2 Change = .029), with social attitudes (p < .05), social behaviours (p < .001), social cognitions (p < .05), internalised transphobia subscales of desire to pass (p < .01), shame (p < .05) and gender (p < .01) adding significantly to the prediction of the level of social anxiety. Regression statistics are reported in Table 3.5.

Table 3.5

Results of hierarchal regression model

Variable	β	t	R	R^2	ΔR^2	R^2 Change
Step 1			.800	.641	.631	.641
SAQ	-.041	-1.385				
SBQ	-.478	-3.955***				
SCQ	.265	2.846**				
Step 2			.822	.675	.655	.035
SAQ	-.054	-1.723				
SBQ	-.478	-4.047***				
SCQ	.207	2.240*				
TIS Pride	.171	1.561				
TIS Passing	-.295	-2.692**				
TIS Alienation	-.395	-1.559				
TIS Shame	.213	1.822				
Step 3			.838	.703	.675	.029
SAQ	-.060	-2.040*				
SBQ	-.507	-4.397***				
SCQ	.173	1.903*				
TIS Pride	.144	1.208				
TIS Passing	-.269	-2.697**				
TIS Alienation	-.337	-1.370				
TIS Shame	.234	2.158*				
NE	.068	.425				
ND	-.113	-.412				
Gender	5.921	3.161**				

Note. N = 120; *p < .05, **p < .01, ***p< .001

Discussion

The present study had two phases; in the first phase, a comparison was made between cisgender and transgender participants, with the expectation that SAD symptoms in the transgender group will be significantly higher than cisgender group and higher in transgender females than males. However, the results indicated that transgender males were the only group to show elevated social anxiety scores, with other groups comparable to each other. In the second phase, where the focus was on comparing transgender clinical samples, differences were hypothesised between transgender men and women on cognitive and behavioural processes involved in social anxiety disorder. There was no evidence of this in these data; nor were any gender identity differences found in proximal stressors. Lastly, it was predicted that, in line with previous research, there would be significant associations between level of social anxiety and cognitive and behavioural processes involved in SAD and that further associations will be found with proximal stressors. These associations were indeed found, although the additional contribution of proximal stressors on social anxiety levels was very small.

Compared to previous research, the frequency of social anxiety in transgender individuals was elevated. For example, in a comparable clinical sample in Bergero-Miguel et al. (2016) found a frequency of 31.4% of social anxiety in a clinical sample of transgender participants, which was much lower compared to 80.1% in our current sample. The reason for this is unclear. A possibility may be that a higher threshold is required to reach the clinical level of social anxiety in the Mini-International Neuropsychiatric Interview (MINI), a semi-structured diagnostic interview used in the referenced study, compared to the SPIN which

depends predominantly on participants' self-report. The current finding that transgender males may have elevated social anxiety scores is in line with previous research by Ho and Mussap (2020) who also found that transgender males had elevated social anxiety scores on the LSAS and TSAS compared to transgender females. Findings were not in line with other studies that found no significant differences (Bergero-Miguel et al., 2016; Gómez-Gil et al., 2008). However, the lack of significant difference in the psychological processes of social anxiety, including cognitive and behavioural processes and proximal stressors, may be more in line with these latter studies.

There were several limitations to the current study. Firstly, the average SPIN scores for all four groups were above the clinical cut-off for social anxiety. When compared to SPIN norms from previous studies in community samples (Caballo et al., 2013; Sosic et al., 2008), social anxiety scores for cisgender participants in this study were higher. It is likely that the comparison cisgender group recruited may be non-typical, as recruitment methods here depended heavily on social media which may have biased the scores as well as the gender proportions of respondents (i.e. female dominant sample). The nature of recruitment posters that advertise the topic that is being studied (in this case, social anxiety) could have attracted respondents who currently or historically have had difficulties with social anxiety. Additionally, there is an inconsistency in findings between transgender males exhibiting elevated social anxiety scores on the SPIN but did not have elevated scores on any of the psychological process measures compared to transgender females, therefore replication is needed. Lastly, other mental health (e.g. depression, anxiety) and neurodevelopmental conditions (e.g. Autism Spectrum Disorder, ASD) that may confound outcomes of the study were not assessed and controlled for.

Findings from the multiple hierarchal linear regression are consistent with Clark & Wells' model of social anxiety, as seen by cognitive and behavioural process measures

accounting for most of the variability in the model, and only marginally consistent with the transgender minority stress model. This may be because the latter model is more transdiagnostic and less focused on predicting social anxiety specifically. Additionally, SPIN measures are aligned with cognitive and behavioural perspectives of social anxiety and therefore it is understandable that scales that align with this theoretical perspective would have high explanatory power. Nevertheless, some proximal stressors still had a small but significant addition to predicting social anxiety, which suggests there is ample potential for further studies to examine more specific minority stress=related social anxiety factors. In particular, the desire to pass and shame-related proximal stress factors may warrant further examination in relation to transgender experiences of social anxiety.

To conclude, the current study examining social anxiety and related factors in transgender populations has found that transgender males have elevated social anxiety scores compared to cisgender participants and transgender females, but overall there were no significant differences in the psychological processes hypothesised to underlie social anxiety between the two gender identity groups. Cognitive and behavioural processes of the established social anxiety model provided the most explanatory power in social anxiety levels, which suggests that the cisgender cognitive-behavioural model of social anxiety is largely applicable to transgender respondents. More research is required to clarify whether gender identity differences in social anxiety are meaningful, and future research can further develop proximal stressor measures that more specifically pertain to predicting social anxiety levels in transgender participants.

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Executive Summary

Examining the relationship between gender identity, psychological processes and social anxiety in a transgender clinical sample

It is well established in the research literature that experiences of scrutiny and negative judgement can be a major risk factor for developing social anxiety disorder (SAD). Despite this, the research literature on the prevalence, nature and experience of SAD in gender minority groups, who are often subject to societal marginalisation and ostracization, continues to be scarce. Although SAD is extensively studied in cisgender populations, the prevalence and gender identity differences in the level of SAD within transgender groups remain unclear.

Two dominant models can be used to help conceptualise SAD in transgender individuals. The first is a well-established SAD model by Clark and Wells (1995), which provides a conceptual model that proposes that SAD is maintained by excessive self-focused attention around how one is perceived, overdependence on internal cues as evidence of social performance, and fear and avoidance of social situations where one could be subject to scrutiny. The second is the transgender minority stress model, which separates minority-related stress into distal (i.e. observable acts of discrimination) and proximal stressors (i.e. internalised appraisals as a result of distal stressors). This is a transdiagnostic model that proposes that psychological distress arises as a result of a combination of proximal and distal stressors. Theoretically, these models are not inconsistent with each other and may be used in tandem for clinicians to better understand social anxiety presentations in transgender populations. However, very little is known about whether these models are indeed applicable to SAD in transgender groups.

The study aimed to examine whether (a) the level of SAD differed between transgender and cisgender individuals, as well as between transgender females and transgender males, (b) there were any differences in cognitive and behavioural processes, as well as proximal stressors, between transgender men and women, and (c) the psychological processes proposed by established models of SAD and transgender minority stress model was indeed associated to levels of SAD in transgender individuals. We hypothesised that the level of SAD would be higher in the transgender group than the cisgender group, and higher in transgender females than males. Secondly, we hypothesised that there would be differences in the psychological processes proposed to underlie SAD between transgender females and transgender males, including cognitive and behavioural processes and proximal stressors. Lastly, we hypothesised that there would be a significant relationship between the level of SAD and cognitive and behavioural processes involved in SAD and further associations would be found with proximal stressors.

A cross-sectional questionnaire design was used in this study, which was split into two phases. The first phase included basic demographic questions and a singular established social anxiety measure (SPIN), aimed at increasing maximum uptake and providing a feed to the second, more extensive part of the survey where only transgender individuals who completed the first phase were invited. 251 cisgender participants and 161 transgender completed the first phase of the study, and 120 transgender individuals completed the second. Quantitative analyses for the first phase included comparing cisgender and transgender participants according to their gender identity group. In the second phase, transgender women were compared to transgender men. A multiple hierarchal linear regression was used to examine the individual contribution of psychological process measures on social anxiety level, with cognitive and behavioural processes in the first model, addition of proximal

stressors in the second, and the addition of gender identity as a dummy variable in the final model.

Overall, contrary to the first hypothesis, only transgender males were found to have elevated social anxiety scores compared to cisgender males, cisgender females and transgender females, with no significant differences between the latter three groups. Contrary to the second and third hypotheses, there were no significant differences found in cognitive behavioural processes, transgender minority stress-related proximal stressors, between transgender males and transgender females. Lastly, in support of the final hypothesis, significant associations were found between cognitive and behavioural processes and social anxiety levels in the transgender group. There was a small but significant additional contribution of minority stress-related proximal processes on social anxiety, particularly with regard to psychological processes around passing and shame.

In conclusion, the current findings are in line with dominant and established cognitive-behavioural models of SAD and suggest that these models are largely applicable to transgender groups as well. Findings suggest that the experience of SAD is also in line with some proximal stressor processes suggested by the transgender minority stress model, and further research is required to specify which proximal stressors are particularly relevant. Study findings are in line with previous studies that have found that transgender males have elevated social anxiety scores compared to transgender females; more research is needed as to why this may be. Given there were no significant differences between transgender males and females in any of the psychological processes explored, a deeper insight into whether this difference is meaningful and how it may present warrants further investigation.

Connecting Narrative

Initial relationship with research

I entered clinical training with very little sense of what my clinical or research interests were. This meant picking out three topics during my first year of training felt quite intimidating. I had previously published my master's thesis on mental health policy, so had some insight into the research process, but to my dismay, this experience provided no further clarity into what areas of research interest I had. Nevertheless, as a trainee clinical psychologist from an ethnic minority background, subconsciously I knew that increasing access and representation was important to me. As I look back on my research journey during doctoral training, I noticed that what connected all three projects was the desire to increase the representation of the study of individuals who may be historically overlooked in the clinical psychology field. In the systematic review on childhood sexual abuse, I was drawn to focus on its impact on men instead of women. In the diversity-related service improvement project, I attempted to make space to acknowledge the challenges of being socioeconomically disadvantaged as an aspiring clinical psychologist, as opposed to a focus on ethnicity and race which diversity initiatives currently predominantly focus on. In my main research project, I wanted to explore experiences of social anxiety in transgender individuals given most of the existing research in the field was based on cisgender samples. My experiences before and during training continue to confirm that, as for now, I enjoy being a "generalist" in clinical psychology research and practice. To me, what area I work in terms of research or clinical work matters less than whether I am following my underlying values and whether I

am utilising and expanding my research and clinical toolkit to become a well-rounded clinical psychologist.

Systematic Review of the Literature

The Impact of Childhood Sexual Abuse on Interpersonal Violence in Men: A Systematic Review

I was keen to learn to conduct a systematic review from start to finish as I have always found them the most useful when consuming research for literature reviews. Over my clinical placements, I was particularly drawn to the experiences of men who have had traumatic experiences in childhood. Typically when we speak of childhood sexual abuse, most focus on the experiences of women. This sparked my curiosity in exploring the ideas of the intergenerational cycle of trauma in men. This project taught me just how useful the structured, critical methodology that a systematic review utilises can be in challenging theories. As a result of this review, I questioned the validity of specific assumptions in the intergenerational transmission of violence, that had face validity and was widely accepted in the field. It helped me develop a keen eye for how the nuances of methodological limitations of studies can shape the overall implications of particular theories and findings.

Service Improvement Project

Improving outreach output to aspiring psychologists from disadvantaged socio-economic backgrounds in the Oxford Institute in Clinical Psychology Training and Research

I was personally very excited by this project as access and representation is important to me, not just with patient groups but also with the representation of clinical psychologists in the United Kingdom currently. This project was my first experience of using thematic

analysis properly and I found the process enriching, meaningful and much more enjoyable than quantitative analyses. I also found a huge degree of flexibility in the way I conducted research in this project, discussing first with working-class trainees from my course and then having various collaborations with schools and University of Oxford outreach initiatives. I was very fortunate that the experiences of socioeconomic disadvantage on one's clinical psychology journey was a topic that was of interest to many and I was able to recruit many participants who took out time and effort to share their experiences in depth.

Theoretically Driven Research Project

Examining the relationship between gender identity, psychological processes and social anxiety in a transgender clinical sample

This project was undeniably the one that appeared the most daunting to me at the beginning. With limited existing literature in the field in general it was hard to generate hypotheses that were theoretically or empirically driven. I have also not had positive experiences with statistical analysis in the past and therefore the anticipation of a quantitative-dominant project was intimidating to me. On the other hand, what I enjoyed the most about this project was speaking with transgender volunteers in the patient and public involvement group about their experiences of social anxiety. It truly reaffirmed the importance of patient and public involvement in research for me and how directly and deeply the benefits of research work can have on people's lives. I held on to this whilst spending endless hours working on data cleaning, statistical analyses and write up. This project helped me become much more familiar with statistical analyses, and I am very grateful for a supervisor who took the time to support me each step of the way.

General reflections for the future

My thesis draws together a range of theories, clinical areas and research methodologies. For a long time, I felt that not specialising in a specific research area in clinical psychology would be a disadvantage for me, but over this research journey, I found that this eclectic range of studies helped me gain confidence in the flexibility and capacity to delve into very different topics with core research skills, a bit of curiosity and courage to learn and troubleshoot on the way. Even though it was challenging at times, I realised how much I enjoyed the systematic process of research, and it still feels surreal to see three years of intense work all in one place. In the future, I hope to bring an open and inquisitive spirit and research abilities into whichever field I end up working in.

Acknowledgements

First and foremost, I would like to thank all the participants who have been involved in my research projects. Without you, this thesis would not exist. I hope that what I have produced accurately reflects your experiences and the final products feel relevant and insightful. I will endeavour to disseminate this work, which you have been a crucial part of, to the wider world. I also want to thank those who have been involved in the co-production process of two of my projects, namely the PPI research group from the Gender Identity Service and trainees on my course who have had lived experience of being from a working class background. You gave me the confidence and direction I needed to explore unfamiliar grounds.

Thank you to my research supervisors at the Oxford Institute of Clinical Psychology Training – Prof. Paul Salkovskis, Dr. Alastair Pipkin, Dr. Reena Vohora and Dr. Fiona Williams – for supporting me through the projects. In particular, I would like to thank Prof. Paul Salkovskis for the countless hours supporting me with research design and statistical analysis for two of my projects. Secondly, I would like to thank Dr. Alastair Pipkin for being the most incredible external supervisor, cheerleader and mentor.

On a personal note, I am beyond grateful for the support from the 2020 cohort, for being there to provide solidarity and support to the endless challenges faced over three years of balancing research, clinical work and life in the midst and aftermath of the pandemic. I continue to be inspired by the level of kindness, thoughtfulness and humour each of you have. Thank you to mum and dad – although we have only seen each other twice over the

course of this doctorate, your love and care are felt deeply despite the distance. Making you both proud has undoubtedly been a major motivator. Finally, to Andrés – without your boundless patience and care, I would not have been able to reach the end.

Appendix 1.1 - Author guidelines for Violence and Aggression

Introduction

Submission to this journal proceeds totally online and you will be guided stepwise through the creation and uploading of your files. The system automatically converts your files to a single PDF file, which is used in the peer-review process.

As part of the Your Paper Your Way service, you may choose to submit your manuscript as a single file to be used in the refereeing process. This can be a PDF file or a Word document, in any format or layout that can be used by referees to evaluate your manuscript. It should contain high enough quality figures for refereeing. If you prefer to do so, you may still provide all or some of the source files at the initial submission. Please note that individual figure files larger than 10 MB must be uploaded separately.

References

There are no strict requirements on reference formatting at submission. References can be in any style or format as long as the style is consistent. Where applicable, author(s) name(s), journal title/book title, chapter title/article title, year of publication, volume number/book chapter and the article number or pagination must be present. Use of DOI is highly encouraged. The reference style used by the journal will be applied to the accepted article by Elsevier at the proof stage. Note that missing data will be highlighted at proof stage for the author to correct.

Formatting requirements

There are no strict formatting requirements but all manuscripts must contain the essential elements needed to convey your manuscript, for example Abstract, Keywords, Introduction, Materials and Methods, Results, Conclusions, Artwork and Tables with Captions.

If your article includes any Videos and/or other Supplementary material, this should be included in your initial submission for peer review purposes.

Divide the article into clearly defined sections.

Please ensure the text of your paper is double-spaced—this is an essential peer review requirement.

Figures and tables embedded in text.

Please ensure the figures and the tables included in the single file are placed next to the relevant text in the manuscript, rather than at the bottom or the top of the file. The corresponding caption should be placed directly below the figure or table.

Peer review

This journal operates a single anonymized review process. All contributions will be initially assessed by the editor for suitability for the journal. Papers deemed suitable are then typically sent to a minimum of two independent expert reviewers to assess the scientific quality of the paper. The Editor is responsible for the final decision regarding acceptance or rejection of articles. The Editor's decision is final. Editors are not involved in decisions about papers which they have written themselves or have been written by family members or colleagues or which relate to products or services in which the editor has an interest. Any such submission is subject to all of the journal's usual procedures, with peer review handled independently of the relevant editor and their research groups. More information on types of peer review.

Appendix 1.2 – Search Strategy

“sexual abuse” OR “sexual assault” OR “sexual trauma*” OR “sexual crim*” OR “rape” OR “incest” OR “molest*” OR “victim*” OR “maltreat*”

AND

“child*” OR “youth” OR “adolescent” OR “young” OR “teen*”

AND

“viol*” or “crim*” or “offen*” or “aggress*” or “danger*”

AND

“men” or “male”

Limitations: Title/Abstract or Abstract, English Language

Appendix 1.3 – Data Extraction Template

General Information	
Paper Title:	
Authors:	
Publication Date:	
Reviewer Initials:	
Date of data extraction:	
Study Characteristics	
Study location:	
Setting:	
Primary aims:	
Study design:	
Recruitment:	
Eligibility:	
Operationalisation and Method of determining CSA:	
Operationalisation and Method of determining sexual and/or physical violence:	
Participant Characteristics	
Sample type:	
Sample size:	
Sample size of men:	
Comparison group (if any):	
Age (mean and SD)	
Ethnicity:	
Measures and Outcomes	
Types of outcome measures (self-report, external	

records)	
Psychometric properties of measures:	
How CSA ascertained through measures:	
How sexual/physical aggression ascertained through measures:	
Other measures used:	
Results	
Statistical analytics used:	
Association between CSA and sexual and/or physical violence:	
Confounding variables considered:	
Conclusions	
Author's conclusions:	
Limitations:	
Notes:	

Appendix 1.4 KMET Quality Appraisal Tool (Adapted)

Author names (date)	YES (2)	PARTIAL (1)	NO (0)	N/A*
1 Question / objective sufficiently described?				
2 Study design evident and appropriate?				
3 Method of subject/comparison group selection *or* source of information/input variables described and appropriate?				
4 Subject (and comparison group, if applicable) characteristics sufficiently described?				
5 If interventional and random allocation was possible, was it described?				N/A
6 If interventional and blinding of investigators was possible, was it reported?				N/A
7 If interventional and blinding of subjects was possible, was it reported?				N/A
8 Outcome and (if applicable) exposure measure(s) well defined and robust to measurement / misclassification bias? Means of assessment reported?				
9 Sample size appropriate?				
10 Analytic methods described/justified and appropriate?				
11 Some estimate of variance is reported for the main results?				
12 Controlled for confounding?				
13 Results reported in				

sufficient detail?				
14 Conclusions supported by the results?				
**Grey area = criteria must be scored and not given and N/A; N/A = not applicable to the nature of the studies included in the current systematic review.*				

Appendix 1.5 - Acronyms for Data Extraction Table

Note. (-) No psychometric validation, (+) Psychometrically validated, (?P) - Unknown psychometric properties, (A) – Items were adapted, ? – Unknown due to unreported, %M – Percentage of males, ACE - Adverse Childhood Experiences, ASTB – Antisocial Traits and Behaviours, BA – Black African, C – Caucasian, CPA – Childhood Physical Abuse, CR - Court report, CSA – Childhood Sexual Abuse, CSVQ - Child Victimisation Questionnaire, CTQ - Child Trauma Questionnaire, CTS - Conflict Tactics Scale, CTS2 - Conflict Tactics Scale 2 / Revised Conflict Tactics Scale, DV - Domestic violence, EN - Emotional neglect, FEA - Family emotional abuse, ICD-10 - International Classification of Diseases 10th Version, IPV – Intimate Partner Violence, ITO - Injury to other, LAGG - Lifetime Aggressive Acts, LAVA - Lifetime Assessment of Violent Acts, *M* – mean, MA - Motivated Acts, MDD – Depression, Multi – Multivariate analysis, OPV – Observed Parental Violence, PA – Physical abuse, PB - Peer Bullying, PN - Physical Neglect, PPA - Parental Physical Abuse, PRP - Personal Relationship Profile, PSV - Psychological Violence, PTSD - Post-traumatic Stress Disorder, PV – Physical Violence, SA – Sexual Abuse, SAb – Substance Abuse, SAS-SR (D/C)- Sexual Abuse and Assault Self-Report (Dimensional/Categorical Index), SAV-S - Sexual Aggression and Victimisation Scale, SDS - Sexual Deviance Scale, SES - Sexual Experiences Survey, SEQ – Sexual Events Questionnaire, SPA - Sibling Physical Abuse, SR – Self-reported, SSI - Semi-structured Interview, SSS – Sexual Strategies Scale, SU – Substance Use, SV – Sexual violence, SVS - Sexual Violence Scale, TVA - Trouble from Violent Acts, Uni – Univariate analysis, VA - Verbal Abuse, VEQ-R - Violent Experiences Questionnaire

Appendix 2.1 - Author Guidelines for Clinical Psychology Forum

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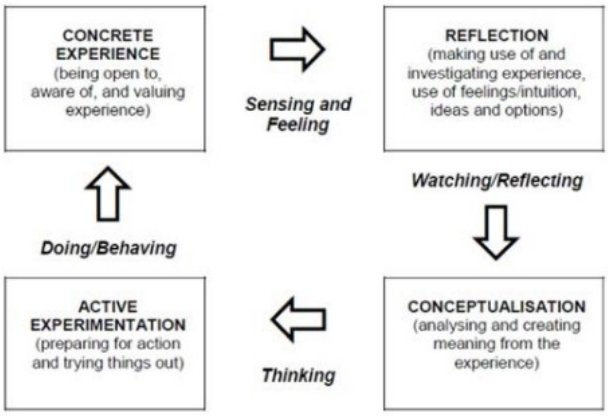


Opinion pieces/position statements/ research summaries (not more than 3500 words, including references but not first page or abstract, unless by editorial agreement)

We welcome papers describing ideas, exploring topical issues or reflecting on current practice.

Authors may wish to discuss the suitability of their contribution with the editors before submitting, and at this point, advice could be provided as to length, structure etc.

The submissions should be well-structured, clearly addressing a current issue and explaining why it is relevant to CPF readers. There should be some novel exploration of ideas, or old ideas presented in relation to a current issue. In order to appeal to the largest number of readers, papers which are relevant cross-speciality are encouraged.

Other notes

We welcome new writers and have several reviewers who have expressed an interest in mentoring new writers in the submission process. Please feel free to contact the editors if you have a paper you would like to go through an initial screening and advice process before being formally submitted for review.

Pre-qual psychologists are also very welcome to submit. Please discuss your submission ideas with your supervisor or manager both as a quality check prior to submission, but also to ensure your organisation supports the sharing of your project/data.

Editorial feedback

After submission, your paper will be assigned to a reviewer.

CPF reviewers have varied backgrounds and areas of expertise. We try to match your submission with someone with knowledge of your area.

Submissions are usually reviewed in approximate chronological order of receipt but this will depend on when we have special editions of the periodical and this may delay or promote the time of your review.

You will usually receive one of four responses:

- Not suitable
- Suitable but requiring major revisions
- Suitable but requiring minor revision
- Suitable without further revision

The degree to which your revisions are directed will depend on the extent of the reviewers' comments.

If you are asked to resubmit we require a submission as a **word document with tracked changes** to alert us to where the revisions are in the text. We also require an accompanying letter or email with a **bullet pointed list of how you have addressed each of the requests for change** made by the reviewer.

Appendix 2.2 - Published article on Clinical Psychology Forum

Experiences of socioeconomic

Aika Hui

career for those who are currently underrepresented.

Whilst there is growing attention on increasing the representation of ethnic minority workforce in clinical psychology, less attention has been placed on those who come from socioeconomically disadvantaged background. Though intersectionality is likely being considered by doctorate training courses independently, the current focus of Health Education England (HEE) funding is on increasing support for aspiring psychologists from an ethnic minority background. This may eclipse the need for support for individuals from low socioeconomic backgrounds of all ethnic and racial backgrounds.

It is important to explore the experiences of aspiring or trainee clinical psychologists from a disadvantaged socioeconomic backgrounds as they are undeniably a minority group in the field of clinical psychology. Not only are they underrepresented at application stage compared to those from a higher socioeconomic status, they have also for some time been underrepresented in training programmes than those from a higher socioeconomic status. Based on five years of data from the Clearing House Equal Opportunities Data collated between 2015 and 2020 (Clearing House for Postgraduate Courses in Clinical Psychology, 2020), there were only approximately 10 per cent of applicants from Participation of Local Areas (POLAR) Quintile 1 (lowest socioeconomic quintile) compared to 33 per cent from POLAR Quintile 5. More concerningly, between 2015 and 2020, the percentage of Doctorate of Clinical Psychology (DClinPsy) acceptances from POLAR Quintile 1 was approximately 7 per cent compared to approximately 38 per cent from Quintile 5. Although there is limited data on the distribution of socioeconomic backgrounds of qualified clinical psychologists, in all likelihood this has and continues to contribute to the overall underrepresentation of qualified clinical psychologists from socioeconomically disadvantaged backgrounds. Contributing factors to underrepresentation include the effect of low socioeconomic status on A-level and university grades (Goodman & Gregg, 2010) which subsequently impact on poorer academic performance. Both of these likely contribute to the chances of a successful DClinPsy application (Scior et al., 2007). In the continuing efforts towards inclusion in clinical psychology, understanding the experiences of those who are socioeconomically disadvantaged and are already on training as well as those aspiring to become a clinical psychologist is important, as this can help shape the directions of proactive initiatives that help engage and support future cohorts of clinical psychologists in the formative years of their careers.

Method

Aspiring and trainee clinical psychologists self-identifying as from a socioeconomically disadvantaged background across the United Kingdom were invited to complete an online survey. The aim of the survey was to explore how they felt their socioeconomic background impacted their experiences of pursuing clinical psychology as a career, focusing on experiences of practical and perceptual barriers they may have experienced. Two trainee clinical psychologists self-identifying as from a socio-economically disadvantaged background provided feedback to the pilot version of the survey. The final version was advertised via social media (Instagram and Twitter) to recruit participants.

The survey included demographic information on the respondents' socioeconomic characteristics and stage in their clinical psychology journey. Due to the complexities of quantifying social class and socioeconomic status (Rubin et al., 2014), demographic questions were not used as a screening tool to determine whether someone was socio-economically disadvantaged or not, but rather as a way to collect descriptive information on the overall socioeconomic related characteristics of respondents. Open-ended questions on respondents' experiences on how they felt their background may have interacted with their experiences and attitudes towards clinical psychology were asked.

Appendix 2.3 – POLAR Classifications System

POLAR Quintiles

"The participation of local areas (POLAR) classification groups areas across the UK based on the proportion of young people who participate in higher education. It looks at how likely young people are to participate in higher education across the UK and shows how this varies by area. POLAR classifies local areas into five groups - or quintiles - based on the proportion of young people who enter higher education aged 18 or 19 years old. Quintile one shows the lowest rate of participation. Quintile five shows the highest rate of participation." – Office for Students (OfS)

POLAR classifications are used by DClinPsy courses to ascertain the socio-economic status of the applicant. Currently, this is only used as descriptive data and not used in the admissions process. For more information on the POLAR classification system, please see: https://www.officeforstudents.org.uk/data-and-analysis/young-participation-by-area/about-polar-and-adult-he/

Appendix 2.4 - Motivations and barriers to applying to Oxford (extended)

Motivations and barriers to applying to OXICPTR: themes and subthemes (extended)

Themes	Sub-themes	Statement Examples*
Motivations to apply to OXICPTR	I like what the course can provide	"The course content and lecturers associated with the course." (P53, aspiring)
		The course content, professors, academic rigour (P27, aspiring)
		…research excellence, interesting placements, systemic training (P75, aspiring)
	It's close to home	"I was living in the Oxford area and had connections around there, knew a lot of the services in the area & therefore what placements were offered." (P146, non-Oxford trainee)
		"Location as I live in Oxford" (P33, non-Oxford trainee)
		"It's located in the geographical region I live in (the Thames Valley)" (P130, non-Oxford trainee)
	I want to prove to myself and others	"Proving to everyone I can achieve at the highest level." (P113, Oxford trainee)
		"Being selected to be hired for a competitive role - made me realise I could achieve things I previously thought might not be possible for me." (P65, aspiring)
		"The course structure looks really good and getting a degree from Oxford would be amazing" (P8, aspiring)
Barriers to applying to OXICPTR	The selection criteria works against my strengths	"My SE background means I didn't do as well academically in a levels due to my environment/emotional and financial strain and so the points scoring system plays against me in this despite having lots of other strengths." (P47, aspiring)
		"I didn't end up applying because I saw on their website that they first eliminate people based on A-level results, so I didn't want to waste my option" (P22, aspiring)
		"Although Oxford present themselves as wanting to diversify, the academic scoring system does not match this statement. As per the website I would only score 16 out of 40 points, meaning it would be highly unlikely I would be shortlisted for interview. My education has been directly impacted by my social-economic background. It is not financially viable to complete a masters, and the only postgraduate study I have (funded PGDip) would not be

	allocated points.” (P106, aspiring)
	“First round academic scoring/filtering system. As the first person in my family to complete a levels, go to university, and the standard of schools I attended, my grades achieved at a level don't necessarily represent my intellect” (P247, aspiring)
The city is too expensive	“…Oxford is very expensive to live in and doesn’t have weighted pay to reflect this.” (P9, non-Oxford trainee)
	“Money - there’s no feasible way of me moving to oxford on the trainee wage without financial support from family which is not possible in my situation as I have only 1 working parent and 1 on income support.” (P40, aspiring)
	“Oxford is an expensive place to live, so that’s a worry in itself.” (P66, aspiring)
I’ll be the odd one out	“There is a whole belief about Oxford being full of posh, privileged people from private schools (and potentially tories) that has put me off.” (P35, aspiring)
	“Don’t think I’d be accepted or fit in. Welsh students from my area are seem to be seen as having a pity acceptance if any to unis like oxford” (P30, aspiring)
	“I don’t feel that I would relate to people on the course or people who live in Oxford.” (P212, aspiring)
	“Seems to be a ‘type’ who get into this course- a ‘type’ I don’t fit into to.” (P244, aspiring)
Never crossed my mind as a possibility	“…Coming from a low income background, it isn't even considered to be an option.” (P272, aspiring)
	“I didn't feel that it was even an option. Too prestigious.” (P24, non-Oxford trainee)
	“Never believed I would get into Oxford! Also not sure I would enjoy living there as it lacks diversity” (P242, aspiring)

Appendix 2.5: Barriers to Clinical Psychology (extended)

Practical and perceptual barriers to Clinical Psychology: themes and subthemes (extended)

Theme	Sub-theme	Statement Examples*
Practical barriers to Clinical Psychology	You can't be what you can't see	I didn't go to a selective school, so didn't get that opportunity to speak to universities at outreach events, parents have no qualifications even between them so had no idea what an academic career even looks like, let alone something more vague like a psychology career. (P22, aspiring) "I haven't had access to as much information as others may have, my schools didn't really bother with careers and my parents don't understand the world of psychology and English isn't our first language so upon moving to the U.K. the only job my dad has been able to get is HGV driver. Therefore, they haven't been able to help me in anyway with my degree and other qualifications" (P6, aspiring) I am pursuing clinical psychology after already completing a degree in an unrelated subject. Psychology never felt like an option for me growing up - I had no family members or role models who worked in health care. It was never spoken about in school as an option. (P274, aspiring)
	Performance versus potential	"… I did not have a permanent home till I was 16 which led to me going to 5 different schools by the time I was in year 10. This made it hard to engage with studies." (P48, aspiring) "Due to my student debt, high living costs, trying to help my family, etc I wasn't able to volunteer for positions or take lower paying AP positions as it was not financially viable" (P102, aspiring) "Financial barriers as I had to work alongside my undergrad which meant less time for focussing on my studies, and so I didn't get as good a grade as I wanted." (P170, aspiring)
	It feels impossible to afford what it takes	"I had to work during my undergraduate to pay my rent. This stopped me from doing relevant volunteering…I had to work 2 years to save up to do a masters and I still had to do it part time and worked full time. I couldn't afford to relocate for jobs…I had to turn down assistant jobs because I would have been in too much debt trying to live off a band 4 salary." (P24, non-Oxford trainee) "After my BSc, an MSc was simply off the cards due to cost. To pursue further study I had no choice but to commit to a 4 year PhD because it gave me a stipend and I had no fees to pay. I am currently training on a London course, but would not have been able to afford this were I not living with my partner who is from a more wealthy background." (P155, non-Oxford trainee)
Perceptual barriers to Clinical Psychology	Am I late to the game?	"I didn't know a career in psychology existed until I was in my twenties…I couldn't catch up in terms of knowledge and experience. I often have thoughts that I'm not well-educated enough to pursue this career." (P66, aspiring)

	"I am not as aspirational as middle and upper class students (although I wasn't aware of this until later in life - I am a mature student). I also had very little career guidance. I didn't know universities were looked down upon, I just thought a degree was a degree." (P43, aspiring)
	"Parental estrangement meant I haven't been able to pursue my desired career until much later in life. I was unable to attend university at 18 due to adverse life experiences and lack of financial and social support. I had my children in my early twenties, so could not afford to attend uni until I was 30." (P112, aspiring)
I don't fit the mould	…I would often feel like a bit of an outsider or a bit, for want of a better word, "rough"…I often found myself making a joke about my hometown before anyone else did so that I wouldn't feel embarrassed… I worry about the impact of my regional accent when I start applying for DClinPsy courses next year. (P42, aspiring)
	"…seeing little representation in the profession sometimes feels as though its a career for those who grew up surrounded by academics and opportunities." (P138, aspiring)
	"I would say that coming from a low SES and somewhere in between working/middle class has made me feel more like an outsider in the profession, maybe have also struggled with confidence as I don't fit a standard stereotypical CP." (P120, non-Oxford trainee)
I have to work twice as hard	"I'm aware that it'll take me twice as long and I'll have to work much harder to get roles that privileged people get." (P213, aspiring)
	"Yes, I feel more of a disadvantage. I feel as though I need to work harder than those around me" (P69, aspiring)
	"At times it has made it feel more of a challenge (in an already challenging and competitive career) to feel able to 'fit in' and feel 'the part'." (P172, non-Oxford trainee)
The instability scares me	"Training is precarious and I debated going into a more steady career where I could earn money or risking psychology and potentially low paid roles and not getting on the training." (P79, non-Oxford trainee)
	"Knowing how competitive it is, it's quite off putting to know that you might not get a stable job after graduating. This made me consider other careers where there was definite (or at least more certain) career progression with good pay." (P65, aspiring)
	"Yes - it's stirs a lot of uncertainty around income as I have nothing to fall back on. Major risk to take when you come from a low socio-economic background because you may never get on but need to support yourself financially whilst navigating your next steps." (P244, aspiring)
	"If an individual has a roof over its head and stable household to live in, I believe that's the first fundamental step to build a concrete clinical psychology career." (P46, aspiring)
My background is	"I think it can be positive by helping understand why those in lower

	a double edged sword	SES backgrounds may not want to get help but it can also make you doubt yourself and think you're not good enough because you don't know fancy words or your accent/area your from may lead to judgement." (P30, aspiring) "…although I believe I can get on the course, going through my career has opened my eyes to how under represented some groups are in the field of clinical psychology, and the many social economic barriers there are for people wanting to apply." (P33 aspiring) "…I want to help people to manage mental illness having experienced it myself and grown up around people with mental illnesses. However, it is SUCH a competitive field and I have consistently felt the barriers go up around me as I have went on the journey to try to get experience to become a clinical psychologist." (P59, aspiring)

Appendix 2.6 – Lay Summary of Service Improvement Project

Lay Summary

It is well known that Clinical Psychology is a competitive field to get into, however this can be even more difficult when an individual comes from a socio-economically disadvantaged background. As a result, much of the field of Clinical Psychology is overrepresented by middle-class individuals who do not represent the majority of service users that frequent services.

This project aimed to help the Oxford Institute in Clinical Psychology Training and Research (OXICPTR) gain more insight into whether there is a significant underrepresentation of those from lower socio-economic backgrounds in their training course. It also aimed to explore ways to help the outreach team of the institute make the most out of outreach activity to improve this representation issue.

Using a mix of quantitative and qualitative methods, we found that OXICPTR indeed displayed this representation gap. It was also found that many aspiring and trainee clinical psychologists from a disadvantaged socio-economic background who chose not to apply to OXICPTR because of the strict selection criteria that was not inclusive of contextual issues but also due to strong stereotypes about Oxford as a city and institution.

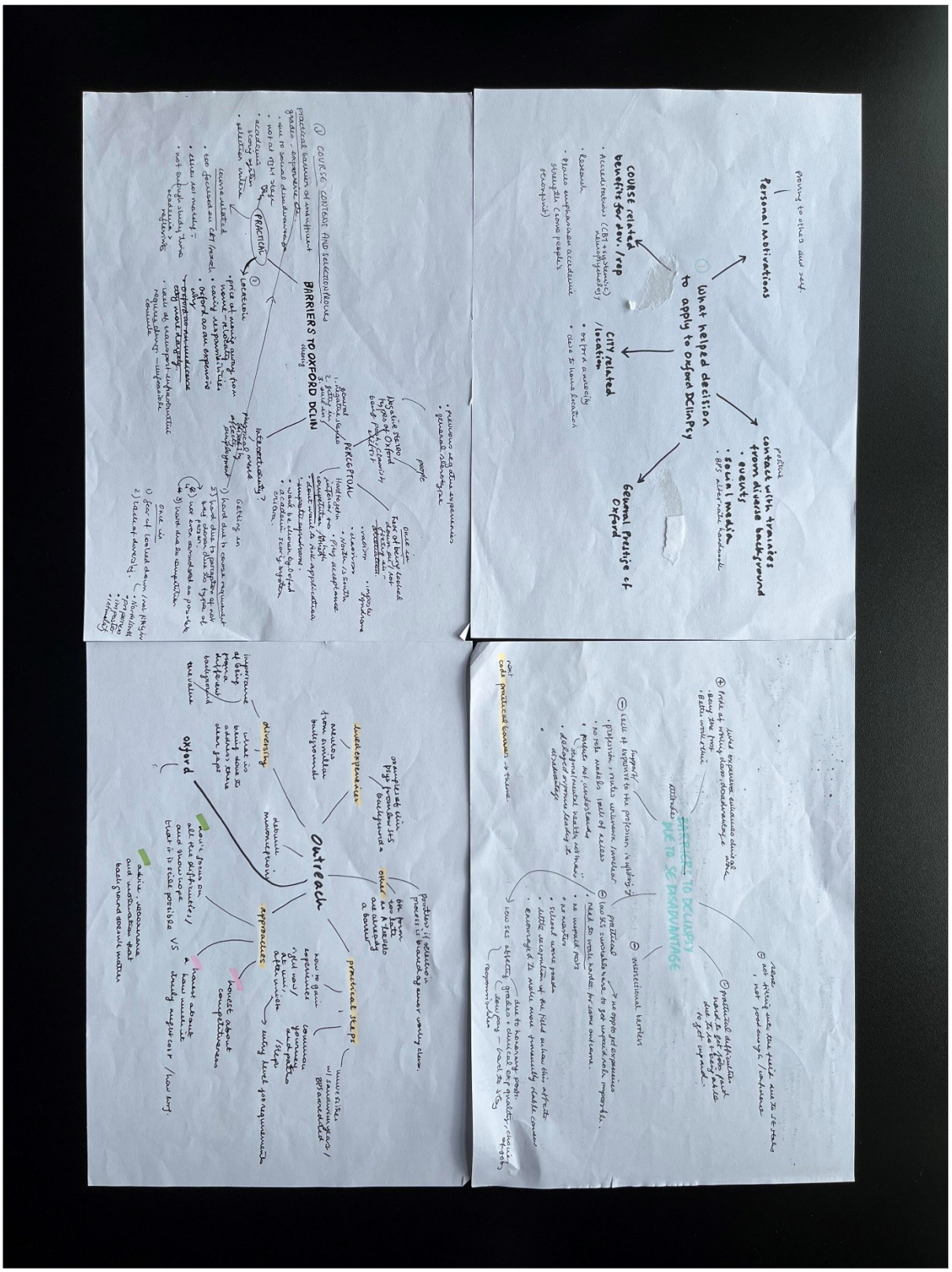
Finally, Psychology A-level sixth-form students from socio-economically disadvantaged backgrounds in the local area were surveyed to explore whether existing outreach content and medium was in line with their preferences. We found that whilst majority were aware of Clinical Psychology, many have chosen not to pursue Psychology at Undergraduate and are not thinking about doing this career. Nevertheless, they reported preferring traditional face-to-face outreach and that they would most likely follow outreach activity through Instagram rather than the institute website and Twitter which is what is currently used by the course.

Appendix 2.7 – Positionality Statement

Positionality Statement

As a child integrated into an extended family who are predominantly ‘working class’, a grandchild of survivors of war and poverty, I have seen vicariously how much socioeconomic privilege in life I have received simply being the daughter of two working-class-turned-middle-class ‘anomalies’ of the extended family. As an ethnic minority, I was very happy to see that issues around BAME representation in Clinical Psychology in the recent years. However I was always curious around the intersectional characteristic of socio-economic disadvantage which I felt was more of a predictor of success in my personal life experiences. I felt that the conversations around socio-economic advantage in Clinical Psychology was long overdue and therefore I felt that as an ethnic minority of a middle class background I could use this privilege to give a voice to other groups who are currently underrepresented as well.

Appendix 2.8 – Examples of Conceptual Maps for Thematic Analysis



Appendix 3.1 - Author guidelines for Journal of Sexual Orientation and Gender Diversity

Journal scope statement

Psychology of Sexual Orientation and Gender Diversity®, the official publication of APA Division 44 (Society for the Psychology of Sexual Orientation and Gender Diversity), is a scholarly journal dedicated to the dissemination of information in the field of sexual orientation and gender diversity. It is a primary outlet for research particularly as it impacts practice, education, public policy, and social action.

The journal is intended to be a forum for scholarly dialogue that explores the multifaceted aspects of sexual orientation and gender diversity. Its focus is on empirical research (both quantitative and qualitative), theoretical and conceptual articles, in-depth reviews of the research and literature, clinical case studies, book reviews, and letters to the editor.

Many issues include a major article or set of articles on a specific theme of importance to theory, research, and/or practice in the psychology of sexual orientation and gender diversity. In addition, articles address professional issues, methodological and theoretical issues, and comments on previous publications in the journal as well as such topics that advance the psychological knowledge of lesbian, gay, bisexual, and transgender individuals and their families, couples and marriage, health and health care, aging, work, and careers.

The journal includes all areas of psychological research, especially developmental, social, clinical, community, counseling, family, gender roles and gender nonconformity, lifespan and aging, cultural diversity including race and ethnicity, and international issues.

Submission

To submit to the editorial office of M. Paz Galupo, please submit manuscripts electronically through the Manuscript Submission Portal in Word Document format (.doc).

Prepare manuscripts according to the Publication Manual of the American Psychological Association using the 7th edition. Manuscripts may be copyedited for bias-free language (see Chapter 5 of the Publication Manual). APA Style and Grammar Guidelines for the 7th edition are available.

Manuscript types

Psychology of Sexual Orientation and Gender Diversity® (PSOGD) accepts a variety of article types consistent with the journal's mission, including:

Standard articles containing a maximum of 7,500 words of text. These will be the most typical articles. Longer, monograph-style articles containing a maximum of 12,000 words of text. These longer contributions will not be typical and to be considered, must provide a particularly enhanced coverage of the topic addressed. Brief reports are research-oriented and contain a maximum of 4,000 words of text. Case studies are clinically/practice-oriented (including industrial/organization practice) and contain a maximum of 3,000 words of text. All ethical and risk management considerations regarding informed consent, confidentiality, and other relevant concerns must be addressed. Case studies must also situate the case in question in relevant theoretical, empirical, and methodological matrices.

Letters to the editor should be limited to 500 words. In unusual circumstances, the founding editor may allow a longer limit with the author. Commentaries may address developments in the behavioral sciences and related fields, the legal system, national or world events, as these pertain to the content areas of PSOGD. These should be a maximum of 1000 words, unless a longer length is allowed by the founding editor.

This list is not meant to be exclusive. Other article varieties may be accepted under unusual circumstances. However, authors must contact the editor prior to submission of any other article to discuss and get approval.

As a rule of thumb one double-spaced page of standard font and size text contains about 300 words. If submissions contain an unusually larger number of references for the article type and/or unusually large tables/charts/graphs, authors may be required to reduce these. "Words" refers to words and other symbols or characters.

Qualitative research

PSOGD welcomes a variety of methodologies in its submissions, including quantitative, qualitative, and mixed quantitative/qualitative methodologies.

All submissions are expected to maintain word limits specific to the type of manuscript (see manuscript types); offer replicable methodology; involve an N commensurate with the purpose of the research and which allows reasonable inference; and be written in a concise and focused manner.

In particular, extensive quotations from research participants are ill-advised, and should be limited to a few which are especially evocative of key themes. The theme descriptions should be the predominant vehicle for conveying participants' responses in qualitative research.

Manuscript preparation

Review APA's Journal Manuscript Preparation Guidelines before submitting your article.

Masked submission

Nothing in your manuscript should indicate authors' identities, institutional affiliation, or other identifying features. Common examples include: naming the institution that granted institutional review board approval; citing by name previous publications on which the

current submission explicitly builds; naming specific organizations that cooperated in data collection, etc.

When masking earlier work on which the current submission is based, remember to remove the identifying citation both from the text and the references. Insufficiently masked submissions will be returned to authors for masking before being sent for review, which slows the review process.

Language guidelines

Authors should be cognizant that language and terminologies used to describe sexual orientation and gender diversity have been used in pejorative ways, have undergone transitions, may likely undergo more transitions, and should be used in ways that convey respect yet maintain precision. When APA offers language guidelines or policy statements that address terminology, authors are generally expected to use these guidelines and statements. There are exceptions to this, such as accurately quoting or describing older literature which might use outdated or problematic terminology. If atypical or non-standard language choices are made deliberately (e.g., using "they" as singular in order to be trans-inclusive), this should be explained and documented in a footnote to the manuscript.

Abstract and keywords

All manuscripts must include an abstract containing a maximum of 250 words typed on a separate page. After the abstract, please supply up to five keywords or brief phrases.

PSOGD encourages submissions from all countries and aspires to disseminate knowledge about sexual orientation and gender diversity internationally.

To this end, authors should submit abstracts and keywords in English and, if they wish, in addition provide abstracts in any other language(s) relevant to the submission in question.

Note that all submissions must include an abstract and keywords in English.

PSOGD can publish the main article text only in English.

Public significance statement

Authors submitting manuscripts to PSOGD are required to provide a short statement of one to two sentences to summarize the article's findings and significance to the educated public (e.g., understanding human thought, feeling, and behavior and/or assisting with solutions to psychological or societal problems). This description should be included within the manuscript on the abstract/keywords page.

Formatting

Double-space all copy. Other formatting instructions, as well as instructions on preparing tables, figures, references, metrics, and abstracts, appear in the Manual. Additional guidance on APA Style is available on the APA Style website.

Below are additional instructions regarding the preparation of display equations, computer code, and tables.

Tables

Use Word's insert table function when you create tables. Using spaces or tabs in your table will create problems when the table is typeset and may result in errors.

References

List references in alphabetical order. Each listed reference should be cited in text, and each text citation should be listed in the references section.

Examples of basic reference formats:

Journal article: McCauley, S. M., & Christiansen, M. H. (2019). Language learning as language use: A cross-linguistic model of child language development. Psychological Review, 126(1), 1–51. https://doi.org/10.1037/rev0000126

Authored book: Brown, L. S. (2018). Feminist therapy (2nd ed.). American Psychological Association. https://doi.org/10.1037/0000092-000

Chapter in an edited book: Balsam, K. F., Martell, C. R., Jones. K. P., & Safren, S. A. (2019). Affirmative cognitive behavior therapy with sexual and gender minority people. In G. Y. Iwamasa & P. A. Hays (Eds.), Culturally responsive cognitive behavior therapy: Practice and supervision (2nd ed., pp. 287–314). American Psychological Association. https://doi.org/10.1037/0000119-012

Figures

Preferred formats for graphics files are TIFF and JPG, and preferred format for vector-based files is EPS. Graphics downloaded or saved from web pages are not acceptable for publication. Multipanel figures (i.e., figures with parts labeled a, b, c, d, etc.) should be assembled into one file. When possible, please place symbol legends below the figure instead of to the side.

Permissions

Authors of accepted papers must obtain and provide to the editor on final acceptance all necessary permissions to reproduce in print and electronic form any copyrighted work, including test materials (or portions thereof), photographs, and other graphic images (including those used as stimuli in experiments).

On advice of counsel, APA may decline to publish any image whose copyright status is unknown.

Appendix 3.2 – Copy of Confirmation of HRA Ethical Approval

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Ms Aika Hui
Trainee Clinical Psychologist
Oxford Health NHS Foundation Trust
Oxford Institute of Clinical Psychology Training & Research
Isis Education Centre, Warneford Hospital
Headington, Oxfordshire
OX3 7JX

Email: approvals@hra.nhs.uk
HCRW.approvals@wales.nhs.uk

22 February 2022

Dear Ms Hui

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**Investigating social anxiety among transgender individuals**
IRAS project ID:	**300471**
Protocol number:	**N/A**
REC reference:	**21/NW/0315**
Sponsor	**Northamptonshire Healthcare NHS Foundation Trust**

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

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

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

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

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

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

What are my notification responsibilities during the study?

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

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

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

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

Your IRAS project ID is **300471**. Please quote this on all correspondence.

Yours sincerely,

Kevin Ahmed
Approvals Manager

Email: approvals@hra.nhs.uk

Copy to: *Itai Matumbike, Northamptonshire Healthcare NHS Foundation Trust*

List of Documents

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

Document	*Version*	*Date*
Copies of advertisement materials for research participants [TDRP Social Anxiety Advert Poster]	2	22 November 2021
IRAS Application Form [IRAS_Form_25092021]		25 September 2021
Letter from funder		
Letter from sponsor		
Other [SAQ]		
Other [SBQ]		
Other [SCQ]		
Other [SPIN measure]		
Other [Transgender identity survey]		
Other [TSAS measure]		
Participant consent form [Consent]	2	22 November 2021
Participant information sheet (PIS) [PIS]	2	22 November 2021
Research protocol or project proposal [Protocol]	1	20 August 2021
Summary CV for Chief Investigator (CI) [CV]		20 August 2021
Summary CV for student		
Summary CV for supervisor (student research) [APipkin CV]		
Summary CV for supervisor (student research) [Paul Salkovskis Research CV]		

Appendix 3.3 - Social Phobia Inventory (SPIN)

SPIN

name _____

date _____

beside each statement below, please tick the box that best describes how you have been feeling during the last week or other agreed time period:

		0: not at all	***1: a little bit***	***2: some -what***	***3: very much***	***4: extre -mely***
1	I am afraid of people in authority					
2	I am bothered by blushing in front of people					
3	parties and social events scare me					
4	I avoid talking to people I don't know					
5	being criticized scares me a lot					
6	I avoid doing things or speaking to people for fear of embarrassment					
7	sweating in front of people causes me distress					
8	I avoid going to parties					
9	I avoid activities in which I am the centre of attention					
10	talking to strangers scares me					
11	I avoid having to give speeches					
12	I would do anything to avoid being criticized					
13	heart palpitations bother me when I am around people					
14	I am afraid of doing things when people might be watching					
15	being embarrassed or looking stupid are among my worse fears					
16	I avoid speaking to anyone in authority					
17	trembling or shaking in front of others is distressing to me					

total score =

Appendix 3.4 - Social Attitudes Questionnaire (SAQ)

Name: ……. Date: …….

SOCIAL ATTITUDES QUESTIONNAIRE

This questionnaire lists different attitudes or beliefs which people sometimes hold. Read EACH statement carefully and decide how much you agree or disagree with each statement.

For each of the attitudes, show your answer by putting a circle round the words which BEST DESCRIBE HOW YOU THINK. Be sure to choose only one answer for each attitude. Because people are different, there is no right or wrong answer to these statements.

To decide whether a given attitude is typical of your way of looking at things, simply keep in mind what you are like MOST OF THE TIME.

I don't need everyone's approval

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

I must not show signs of weakness to others

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

If I make a mistake in a social situation people will reject me

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

Everyone will stare at me and think I'm strange if I don't act normally

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

I'm unlikeable

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

Other people are more anxious than I am

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

I'm different

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

Other people are better at getting it right socially than me

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

I must appear intelligent and witty

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

I look as anxious as I feel

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

If other people think I'm inferior, then I am

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

I'm unacceptable

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

Anxiety is not a sign of weakness

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

Other people are more competent than I am

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

Others are more acceptable and likeable than me

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

My anxiety is obvious to other people

TOTALLY	AGREE	AGREE		DISAGREE	DISAGREE	TOTALLY

AGREE	VERY MUCH	SLIGHTLY	NEUTRAL	SLIGHTLY	VERY MUCH	DISAGREE

If someone doesn't like me, it is my fault

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

To be worthwhile, I don't need approval from other people

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

I must not let anyone see I am anxious

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

People think I am uninteresting

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

If others really get to know me, they won't like me

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

Unless I appear calm, cool and collected, people will reject me

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

I'm inferior

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

I'm vulnerable

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

Other people are less anxious than I am

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

People can see right through me, and see my weakness

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

I don't need to be liked by everyone

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

I'm a weird person

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

If people see I'm anxious, they will humiliate, ridicule and discount me

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

If I disagree with someone, they will think I am stupid or will reject me

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

I'm odd/peculiar

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

I'm important to other people

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

People see anxiety as a sign of weakness

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

I have to do things right to be accepted

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

Unless I am witty and interesting, people won't like me

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

If I keep up appearances, I might scrape by

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

My opinions mean nothing

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

When people see that I'm anxious, they see the real, inferior me

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

I'm attractive

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

If people notice I am anxious they will think I am odd

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

People are intolerant of signs of weakness

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

If someone thought that I was inferior to them, I couldn't stand it

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

If I am quiet, people will think I'm boring

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

I'm inadequate

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

If people see I'm anxious, they will think I am weak or inferior

TOTALLY	AGREE	AGREE		DISAGREE	DISAGREE	TOTALLY

AGREE	VERY MUCH	SLIGHTLY	NEUTRAL	SLIGHTLY	VERY MUCH	DISAGREE

I'm interesting

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

If people look at me, it means they are thinking negative things about me

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

I'm a boring person

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

Even if people see my anxiety, it doesn't mean that I am inferior to them

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

I must always live up to other people's expectations

TOTALLY AGREE	AGREE VERY MUCH	AGREE SLIGHTLY	NEUTRAL	DISAGREE SLIGHTLY	DISAGREE VERY MUCH	TOTALLY DISAGREE

Appendix 3.5 – Social Behaviour Questionnaire (SBQ)

SOCIAL BEHAVIOUR QUESTIONNAIRE

Please circle the word which best describes how often you do the following things when you are anxious in or before a social situation.

Use alcohol to manage anxiety	Always	Often	Sometimes	Never
Try not to attract attention	Never	Sometimes	Often	Always
Make an effort to get your words right	Never	Sometimes	Often	Always
Check that you are coming across well	Always	Often	Sometimes	Never
Avoid eye contact	Never	Sometimes	Often	Always
Talk less	Always	Often	Sometimes	Never
Avoid asking questions	Always	Often	Sometimes	Never
Try to picture how you appear to others	Never	Sometimes	Often	Always
Grip cups or glasses tightly	Never	Sometimes	Often	Always
Position yourself so as not to be noticed	Always	Often	Sometimes	Never
Try to control shaking	Always	Often	Sometimes	Never
Choose clothes that will prevent or conceal sweating	Never	Sometimes	Often	Always
Wear clothes or makeup to hide blushing	Never	Sometimes	Often	Always
Rehearse sentences in your mind	Always	Often	Sometimes	Never
Censor what you are going to say	Always	Often	Sometimes	Never
Blank out or switch off mentally	Never	Sometimes	Often	Always
Avoid talking about yourself	Never	Sometimes	Often	Always
Keep still	Always	Often	Sometimes	Never
Ask lots of questions	Always	Often	Sometimes	Never
Think positive	Never	Sometimes	Often	Always
Stay on the edge of groups	Never	Sometimes	Often	Always
Avoid pauses in speech	Always	Often	Sometimes	Never
Hide your face	Never	Sometimes	Often	Always
Try to think about other things	Always	Often	Sometimes	Never
Talk more	Always	Often	Sometimes	Never
Try to act normal	Always	Often	Sometimes	Never
Try to keep tight control of your behaviour	Never	Sometimes	Often	Always
Make an effort to come across well	Always	Often	Sometimes	Never
Planning topics to talk about in advance of a conversation	Never	Sometimes	Often	Always

Appendix 3.6 - Social Cognitions Questionnaire (SCQ)

SOCIAL COGNITIONS QUESTIONNAIRE

Listed below are some thoughts that go through people's minds when they are nervous or frightened. Indicate, on the left hand side of the form, how often **in the last week** each thought has occurred; rate each thought from 1-5 using the following scale:

1. Thought never occurs
2. Thought rarely occurs
3. Thought occurs half of the time when I am nervous
4. Thought usually occurs
5. Thought always occurs when I am nervous

___	I will be unable to speak	___
___	I am unlikeable	___
___	I am going to tremble or shake uncontrollably	___
___	People will stare at me	___
___	I am foolish	___
___	People will reject me	___
___	I will be paralysed with fear	___
___	I will drop or spill things	___
___	I am going to be sick	___
___	I am inadequate	___
___	I will babble or talk funny	___
___	I am inferior	___
___	I will be unable to concentrate	___
___	I will be unable to write properly	___
___	People are not interested in me	___
___	People won't like me	___
___	I am vulnerable	___
___	I will sweat/perspire	___
___	I am going red	___
___	I am weird/different	___
___	People will see I am nervous	___
___	People think I am boring	___
	Other thoughts not listed (please specify):	
___	_____	___
___	_____	___

Appendix 3.7 – Transgender Identity Survey (TIS)

The fc
transg

Strong
Disagr

- 10. I cannot be happy unless I am perceived as a cisgender woman or man.
- 11. Being read (recognized as transgender) makes me try harder to pass.
- 12. I am like other people but I am also special because I am transgender.
- 13. Passing is my biggest concern.
- 14. When I think about being transgender, I feel unhappy.
- 15. Often, I feel weird like an outcast or a pervert.
- 16. I often ask myself: Why can't I just be normal?
- 17. It's much better to pass as female or male than to be recognized as transgender.
- 18. I sometimes feel that being transgender is embarrassing.
- 19. I am proud to be a transgender person.
- 20. If I look the part, talk the talk, and walk the walk of a woman or man, it will allow others to accept me.
- 21. Passing is a standard to measure my success.
- 22.

Appendix 3.8 – Gender Minority Resilience Scale (GMSR)

Negative Expectations (NE) and Non-disclosure/Concealment (ND)

GMSR Page 4

SECTION A: Please indicate how much you agree with the following statements.

NE		Strongly Disagree	Somewhat Disagree	Neither Agree/ Disagree	Somewhat Agree	Strongly Agree
1	If I express my gender identity, others wouldn't accept me.	O	O	O	O	O
2	If I express my gender identity, employers would not hire me.	O	O	O	O	O
3	If I express my gender identity, people would think I am mentally ill, "crazy."	O	O	O	O	O
4	If I express my gender identity, people would think I am disgusting or sinful.	O	O	O	O	O
5	If I express my gender identity, most people would think less of me.	O	O	O	O	O
6	If I express my gender identity, most people would look down on me.	O	O	O	O	O
7	If I express my gender identity, I could be a victim of crime or violence.	O	O	O	O	O
8	If I express my gender identity, I could be arrested or harassed by police.	O	O	O	O	O
9	If I express my gender identity, I could be denied good medical care.	O	O	O	O	O

ND		Strongly Disagree	Somewhat Disagree	Neither Agree/ Disagree	Somewhat Agree	Strongly Agree
1	Because I don't want others to know my gender identity, I don't talk about certain experiences from my past or change parts of what I will tell people.	O	O	O	O	O
2	Because I don't want others to know my gender identity, I modify my way of speaking.	O	O	O	O	O
3	Because I don't want others to know my gender identity, I pay special attention to the way I dress or groom myself .	O	O	O	O	O
4	Because I don't want others to know my gender identity, I avoid exposing my body, such as wearing a bathing suit or nudity in locker rooms.	O	O	O	O	O
5	Because I don't want others to know my gender identity, I change the way I walk, gesture, sit, or stand.	O	O	O	O	O