Exploring Clients’ Experiences of Disclosing Childhood Adversity to Mental Health Professionals

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ABSTRACT

Introduction: There are gaps within existing literature exploring the experiences of clients disclosing childhood adversity to mental health professionals. Whilst research concerning barriers to disclosing abuse and neglect from the professionals' perspective exists, little is known about the clients' experience of disclosure or the facilitators and barriers to disclosing many other forms of childhood adversity. The current study sought to explore the facilitators and barriers that clients face when disclosing their childhood adversity to mental health professionals, in addition to their experience of enquiry about childhood adversity by mental health professionals.

Methodology: Adopting a critical realist approach, a qualitative methodology was utilised to explore the disclosure experiences of 96 participants with childhood adversity. An anonymous, online survey was used to gather descriptive and qualitative data. The latter led to four content analyses.

Results: Several facilitators (dynamics between the client and MHP, the clients' motivation to disclose, disclosure environment) and barriers (influence of the MHP, clients' experiences, and session environment) to disclosure were identified by participants, including facilitators and barriers not previously identified by existing research. A range of emotional responses to mental health professionals' enquiry (or lack of enquiry) about childhood adversity were also identified. Participants reported a range of childhood adversities besides abuse and neglect, including poverty, discrimination, bullying, adverse neighbourhood experiences, and foster care.

Conclusion: The current study contributes to existing research exploring disclosure of childhood adversity and provides insight into clients' experiences of enquiry about childhood adversity by mental health professionals. The identification of facilitators and barriers to disclosing childhood adversity may expand the theoretical knowledge base surrounding the disclosure process and may inform training for mental health professionals and encourage increased provision of trauma-informed care in mental health services. The implications and recommendations for future training and research are considered.

CONTENTS

1. INTRODUCTION

Childhood adversity (CA) is the experience of stressful events in childhood. These experiences have the potential to impact one's psychological and/or physical wellbeing. This study will focus on individuals with experience of CA, and their experience of sharing (or not sharing) what happened to them with mental health professionals (MHPs). The research explores what happened when 96 individuals attempted to access mental health support for the emotional impact of CA and focuses primarily on the facilitators and barriers to disclosing their experiences. The research also explores experiences of being asked, or not being asked, about CA by MHPs. The goal of the research is to obtain a greater understanding of what may facilitate, or act as a barrier to, disclosure of experiences of CA to MHPs.

Research that concerns experiences of CA, and the subsequent impact on physical and mental health outcomes, uses a wide range of terminology, such as child abuse, child maltreatment, early life stress, or childhood trauma. Perhaps the most widely used term for negative experiences in childhood is 'adverse childhood experiences' (ACEs), a term coined by Felitti et al. (1998) in a pivotal study that exposed the dose response relationship between ten varieties of ACEs and several risk factors for many of the leading causes of death in adults. The study led to the development of the Adverse Childhood Experiences Questionnaire (Felitti et al. 1998) (ACE-Q), which is frequently cited in research concerning negative experiences in childhood. It asks about ten categories of ACEs; childhood abuse: physical, sexual or psychological; neglect: physical or psychological; witnessing of domestic abuse; experiences of family members with mental health difficulties; substance abuse or prison sentences; and divorce or separation of parents.

For the purpose of this study, 'childhood adversity' will be used as an umbrella term that encompasses a number of potentially harmful/stressful experiences and/or events occurring in childhood (between the ages of 0-18), some of which were not included in the original ten ACEs. Use of the term 'childhood adversity' enables the current study to refer to a wider number of adverse experiences in childhood. The research will explore individuals' experiences of CA by using an adapted version of the ACE-Q; the Expanded ACEs questionnaire, developed by Cronholm et al. (2015), which, as well as the ten ACEs determined by Felitti et al. (1998), includes the following experiences: witnessing violence, experiencing discrimination, living in foster care, experiencing bullying, and living in an unsafe neighbourhood.

1.1. Prevalence of Childhood Adversity

The prevalence of CA has been explored and estimated both globally and in the UK. The landmark ACE study (Felitti et al., 1998), undertaken in the US, found that, of 9,058 respondents, over half reported at least one ACE. Internationally, it has been estimated that between one-eighth to one-third of the general population have experienced CA (Stoltenborgh et al., 2015). A population study in the UK found that 47.1% of respondents had experienced at least one ACE (Bellis et al., 2013). Estimation rates were similar in Wales; 47% of respondents had experienced one ACE, and 14% had experienced four or more ACEs (Bellis et al., 2016).

There are variations in reported prevalence rates of CA, that may reflect trends in research over time. A review of existing prevalence reports (Stoltenborgh et al., 2014) concluded that many publications focused exclusively on childhood sexual abuse, compared to other forms of CA, such as physical or emotional abuse. Furthermore, reports of childhood maltreatment were mostly collected from developed countries via self-report measures. The widespread use of the ACE-Q, and subsequent lack of a screening tool that identifies all forms of CA, means that research using tools that do not explore social adversity (e.g., poverty, discrimination) may discount the experiences of particular groups that have been disproportionately impacted by social disadvantage. It is therefore difficult to determine an accurate estimation of the number of individuals affected by CA.

Certain populations are at higher risk of experiencing CA. Research has found that higher prevalence rates of ACEs are found in areas of deprivation and high population density (Lewer et al., 2020). Research exploring the prevalence of exposure to CA between genders suggests that males and females have distinct patterns of childhood adversities, with females being significantly more likely to have experienced a more complex, varied range of CA (Haahr-Pedersen et al., 2020). A study exploring gender-typologies of CA concluded that males and females vary in the types of adversity reported and were differentially associated with mental health variables (McAnee et al., 2019).

1.2. The Consequences of Childhood Adversity

1.2.1. Childhood adversity and toxic Stress

Evidence suggests that the experience of biological (such as malnutrition, exposure to disease) and psychosocial (maltreatment, poverty, witnessing violence) adverse experiences in the first three years of life can impact the developmental trajectory of a child, affecting further childhood and life course of the individual (Nelson et al., 2020). A wide range of adverse experiences can trigger a ‘toxic stress response’, the prolonged activation of stress response systems that occurs when a child experiences frequent, intense, or prolonged adversity, resulting in disrupted brain and organ development, in addition to an increase in lifelong risk of physical and psychological disorders (National Academies of Sciences, Engineering and Medicine, 2019).

1.2.2. Biological factors

CA has been linked to a number of leading causes of morbidity and mortality (Merrick et al., 2019). Exposure to adversity in childhood has been reported to result in a myriad of chronic physical health conditions, such as cardiovascular disease, chronic obstructive pulmonary disease, diabetes, obesity, stroke, and some forms of cancer (Merrick et al., 2019; Suglia et al., 2018). Associations have also been made between neurobiological deficits and exposure to childhood maltreatment (Teicher et al., 2016), poverty (Luby, 2015) and low socioeconomic status (Brito and Noble., 2014). Exposure to complex trauma in childhood has been found to significantly impact brain function, impacting hormonal and neural circuits that regulate stress (Nemeroff, 2004). Brain structures that are responsible for the regulation of intense emotions can be deactivated in response to trauma (Dye, 2018).

1.2.3. Psychological factors

Many psychological frameworks have been deployed to explain the psychological impact of CA. A child that is exposed to adversity and trauma may develop abnormal states of consciousness as an adaptation to an unbearable reality. Existing in a climate of constant potential for threat and danger may lead a child to develop capacity for dissociation, suppression of traumatic memories, and separated personality fragments (Herman, 1992). In line with attachment theory (Bowlby, 1969), repeated negative experiences in childhood may result in the development of negative inner working models, thus influencing the child's outlook and expectations of others and the world (Fuchshuber et al., 2019). Experiences of childhood trauma, such as childhood abuse, neglect, and maltreatment, have been associated with fearful, preoccupied, and dismissive attachment styles (Erozkan, 2016). Cognitive theories suggest that childhood trauma may impact a child's developing sense of self (Tezel et al., 2015), and may result in the development of early maladaptive core beliefs and self-schemas (Young, 2003).

1.2.4. Behavioural and social factors

As mentioned, chronic exposure to stress in childhood as a result of adversity, and the subsequent impact on stress reactivity, may influence an individual's executive functions, such as self-regulation (Hughes et al., 2017). This can later lead to risky social behaviours like excessive alcohol consumption (Lee and Chen, 2017), substance use (Afifi et al., 2020), and anti-social behaviour (Esposti et al., 2020). Children that are accustomed to witnessing violence within the home environment may experience the violence they have become accustomed to in peers as normal, and may tolerate this violence, subsequently failing to seek emotional and social support in others (Sheikh et al., 2016).

Low socio-economic status has been associated with higher prevalence of experiences of CA, and CA has been associated with low socio-economic status in later life (Suglia et al., 2022). Furthermore, experiences of CA may negatively impact educational attainment (Schafer et al., 2013), which can subsequently impact financial security, and occupational and social status (Veldman et al., 2015). Individuals who live in areas of deprivation and are of a low socio-economic status may also be impacted indirectly by parental distress (e.g., reduced capacity for consistent parenting, irritability, explosiveness) resulting from a lack of material resources (Gutman and Eccles, 1999).

1.2.5. Mediating factors in outcomes of childhood adversity

There are several mediating factors that may influence the initial and later-life outcome of experiencing CA. Firstly, contextual factors, such as the type, duration, frequency, and timing of adversity can impact long-term effects (Nelson et al., 2020). The timing in which one is exposed to adversity in childhood may impact outcomes (e.g., if adversity occurs during critical periods of brain development, one may be at increased risk for a range of psychological, behavioural, and social difficulties (Nelson and Gabard-Durnam., 2020)). Generally, it appears that the earlier the adversity occurs, the worse the outcome in later life. In cases of childhood sexual abuse, it has been found that the younger a child is when they started experiencing abuse, the longer it takes to disclose abuse (Allnock and Miller., 2013). Findings suggest that the severity of sexual abuse experienced resulted in higher levels of self-reported long-term difficulties, such as low self-esteem and issues with intercourse (Fleming et al., 1999). Research has also found that experiences of childhood sexual abuse is more common in individuals with disturbed and disrupted families, and also in those who reported physical and emotional abuse (Mullen et al., 1994).

There is also evidence of a dose response relation between the number of adverse experiences and increased risk of future difficulties (Webster, 2022). The original ACE study (Felitti et al., 1998) found that individuals who had experienced four or more ACEs were 12 times higher in prevalence of health risks, such as depression, suicidality, and substance use. Individual factors can also impact the outcome of CA; individuals with increased resilience may experience fewer negative outcomes (Windle et al., 2018). A diathesis-stress model has been proposed, suggesting that children who are highly sensitive may be more susceptible to both positive and negative environmental influences (e.g., familial support, comfort) when faced with CA (Scrimin et al., 2018). It is also important to note that children may not be believed when they attempt to express their negative experiences to others, meaning that early intervention is not offered, and that action is not taken to support the individual (Allnock and Miller., 2013), therefore, being believed by professionals (and action being taken earlier) may act as a mediating and protective factor.

1.3. Childhood Adversity and Mental Health Difficulties

1.3.1. Post-Traumatic Stress Disorder (PTSD)

The experience of traumatic events in childhood, such as exposure to CA, can result in the development of PTSD. It is important to distinguish between trauma (cause) and PTSD (consequence). When an individual is exposed to an event, or circumstances in which they perceive/experience strong negative emotions, such as extreme fear, horror, and/or a threat to life, they can experience this as traumatic (Bartlett and Sacks., 2019). However, a minority of individuals who experience trauma go on to develop PTSD, or complex-PTSD; psychological disorders that are characterised by flashbacks, hypervigilance, avoidance of trauma-related triggers, alterations in thoughts and feelings, and altered perceptions of others and the world (American Psychological Association, 2013). CA is understood to predict increased risk of the development of PTSD and complex-PTSD (McLaughlin et al., 2017). Studies have found that exposure to some, but not all, types of CA, are associated with increased risk of developing PTSD (physical, sexual abuse, neglect, and parental mental health difficulties) (McLaughlin et al., 2017)).

1.3.2. Depression and anxiety disorders

Childhood adversities are associated with sustained risk of developing depression in adulthood (Liu, 2017). CA has also been found to negatively impact the course of depression (Klein and Kotov., 2016) and the severity of depressive symptom severity and time before remission (Rhebergen et al., 2012). CA is also associated with increased risk of recurrence of depression (Gilman et al., 2013).

There is also a well-established association between experiences of CA and anxiety-disorders (Poole et al., 2017). Adversity in childhood has been found to result in increased risk of anxiety disorders (Kessler et al., 2010; McLaughlin et al., 2010). The World Health Organisation (WHO) estimated that eradication of adverse experiences in childhood would reduce the worldwide prevalence of anxiety disorders by 31% (Kessler et al., 2010).

1.3.3. Psychosis

A meta-analysis of over 40 studies found that CA is strongly associated with an increased risk of developing psychosis (Varese et al., 2012). A literature review of research exploring associations between childhood trauma, and psychosis and schizophrenia, determined that there is a causal, dose-effect relationship between experiences of childhood trauma and psychosis and schizophrenia. It was also estimated that retrospective reports of childhood abuse are underreported in individuals with psychosis (Read et al., 2005). There is also evidence that exposure to multiple adversities that involve experiences of hostility and threat, can contribute to a range of psychosis across a spectrum from experiences to psychotic disorders (Morgan and Gayer-Anderson, 2016). A prospective study found a bidirectional relationship between experiences of trauma and psychosis; cessation of trauma was associated with subsequent cessation of experiences of psychosis (Kelleher et al., 2013).

1.3.4. <u>Suicidality</u>

CA has been found to strongly predict the onset and persistence of suicidality (Enns et al., 2006). A study spanning 21 countries found that CAs were associated with increased risk of suicidality (attempts and ideation). Those who had experienced multiple adversities were at higher risk of suicidality, with sexual and physical abuse consistently being the strongest risk factors for the onset and persistence of suicidality (Bruffaerts et al., 2018).

1.3.5. <u>Recommendations</u>

Overall, there is a wide body of research highlighting the causal role of CA on the development of many psychological and physical health difficulties. Such findings have resulted in recommendations for early detection of childhood adversities (Kessler et al., 2010) and routine enquiry within services (Pearce et al., 2019), with the hope of preventing and mitigating the long-lasting effects of exposure to CA. A key determining factor in early detection and providing individuals with the appropriate support to aid recovery, is the disclosure of CA (Easton, 2014).

1.4. Disclosure and Enquiry of Childhood Adversity

1.4.1. <u>Understanding Trauma</u>

The history of the study and understanding of childhood trauma has been described as one of ‘episodic amnesia’ (Herman, 1992), arising in the 1890’s through patriarchal interest in the study of ‘hysteria’, which was linked to the experience of intensely distressing events. Freud arguably did untold damage to the study of trauma, by dismissing his own traumatic theory of the origins of hysteria, in favour of the notion that women desire and imagine sex with their fathers (Bulut, 2019). Interest in psychological trauma in adult men resurfaced following the World Wars and Vietnam Wars, and the progression of the feminist movement, that subsequently highlighted the plight of women and children (Figley, 2002). In more recent years, following increased understanding and general consensus that traumatic experiences and CA can have lasting, detrimental impacts on psychological and physical health, public health initiatives (Department of Health, 2015; HM Government, 2015) have attempted to facilitate the implementation of routine and systematic enquiry about experiences of CA in mental health services to allow for more targeted support at earlier stages of intervention. The REACh (Routine Enquiry about Adversity in Childhood) training programme (is an example of increased attempts to provide MHPs with training around enquiry of CA (Quigg et al., 2018).

However, despite the introduction of policy and training surrounding routine enquiry of sexual abuse/assault (Department of Health, 2008), there is evidence that mental health services may not be implementing policy on routine enquiry, and that there is a lack of governance surrounding policy implementation. A systematic review of 21 studies, conducted by Read et al. (2018), found that audit rates for implementation of routine enquiry were low, with only 9% of 53 mental health trusts auditing this activity (Brooker et al., 2016). The review also found that mental health service users reported low rates (between 0-21%) of enquiry about child abuse, and that there were low rates of abuse and neglect being reported in clinical files, that the researchers themselves had been able to identify. The review concluded that there is a need for greater governance and implementation of policies that compel routine enquiry and trauma-informed care.

1.4.2. The dominance of the medical model

Research surrounding trauma and PTSD, and our subsequent understanding of what may cause and maintain psychological distress relating to trauma, has been negatively impacted by the bio-medical model of mental illness. The bio-medical model maintains a focus of the pathology of mental illness, seeking to diagnose and treat symptoms through use of psychopharmacological or psychotherapeutic interventions, drawing on research that is often concerning genetic and bodily dysfunction, including chemical imbalances in the brain. (Ryan et al., 2008). The dominance of the medical model has resulted in a bias within research funding and priorities towards reductionist biological and genetic research, despite the failure of such research in producing replicable evidence that informs development of interventions (Read et al., 2009). This bias has ultimately led to an underdeveloped understanding of the complex interactions of social, psychological, and biological factors and their impact on the production and maintenance of psychological distress, thus making it difficult to understand people’s experiences of distress within the wider context of their lives (Johnstone and Boyle., 2018).

1.4.3. Trauma-informed care

The move towards systematic and routine enquiry is in line with a substantial shift within the field of psychology to a trauma-informed care (TIC) approach; a framework that integrates knowledge and understanding of the impact of trauma to allow for realisation, recognition, and response to trauma at an individual, service level, and policy level within mental health care (Substance Abuse and Mental Health Services Administration, 2014). Shifts towards a trauma-informed approach have also led to the development of frameworks, such as the Power Threat Meaning Framework (PTMF) (Johnstone et al., 2018), that allow an alternative stance to the dominant, reductionist, biomedical model that locates psychological distress within an individual, and promotes bio-genetic causal explanations, diagnosis, and reduction in symptomatology via use of medication. The PTMF instead promotes the exploration of the impact of power and adversity on an individual and asks, ‘what has happened to you’ rather than ‘what is wrong with you’ (Read and Harper, 2020). The PTMF draws from a substantial amount of literature that considers the impact of social context and CA on psychological distress (Johnstone et al., 2018).

1.4.4. Childhood adversity and routine enquiry

Despite evidence that individuals who access mental health services display high prevalence rates of CA (Bentall et al., 2014), enquiry rates are persistently low. A systematic review found that most individuals presenting to mental health services with experiences of childhood abuse/neglect were never asked about those experiences (Read et al., 2017). Research suggests that many people are unlikely to disclose experiences of CA spontaneously (Read and Fraser, 1998), highlighting the importance of enquiry. It is estimated that, if an individual is not directly asked about their experiences of CA or abuse, it can take between 9-16 years for an individual to disclose (Read et al., 2006). It has been found that males, older individuals, and individuals with a diagnosis of psychosis are less likely to be asked about experiences of abuse or neglect (Read et al., 2017).

1.4.5. Barriers to MHPs asking about childhood adversity

The barriers that MHPs face when enquiring about their clients’ experiences of CA have been explored. Several barriers have been identified, such as: MHPs feeling that there were more pressing issues to discuss, a fear of disturbing clients or inciting ‘false memories’ (Young et al., 2001), lacking confidence in enquiring about past trauma and subsequently responding to possible disclosures (Pearce et al., 2019), and a general discomfort of asking about experiences of abuse (Read et al., 2007). There have also been findings that MHPs are unsure about the appropriate timing to discuss abuse, with some feeling that it was more appropriate to wait until a therapeutic relationship has been established (Young et al., 2001; Kennedy et al., 2020), with others arguing that, for those who have been abused, asking about abuse helps to build a therapeutic relationship (Read et al., 2005). MHPs may also believe that it is therapeutic for a client to disclose their childhood experiences at their own pace (Walsh et al., 2022).

1.4.6. Facilitators to MHP’s enquiry about childhood adversity

There is even less research about the facilitators of enquiry about CA. A thematic analysis exploring barriers and facilitators to enquiry found that MHPs may enquire about child abuse and neglect based on their beliefs that such experiences are common in individuals presenting to mental health services, in addition to the belief that other MHPs do not routinely ask (DuSoulier, 2022). It has also been found that confidence gained through appropriate training and experience may encourage increased enquiry (Pearce et al., 2019). A systematic review of experiences of enquiry (Ashe et al., 2022) found that increases in confidence, knowledge, and training, improved integrative practice between teams, and supportive supervision, aided the process of enquiry. Research into training MHPs to enquire about CA found that a one-day training course in trauma enquiry was effective in increasing rates of enquiry about physical abuse, but not childhood sexual abuse, or emotional abuse and neglect (Lotzin et al., 2019), suggesting that training ought to be longer, and can be enhanced by ongoing supervision. A systematic literature review found that trauma-related training is significantly associated with increases in detection of trauma histories, and frequency of enquiry of trauma histories (Coyle et al., 2019). Training regarding trauma enquiry has also been found to increase clinician's knowledge, attitudes towards, and confidence in asking about experiences of trauma (Lotzin et al., 2018).

1.5. Disclosing childhood adversity

1.5.1. What impacts disclosure of negative experiences?

As with prevalence rates of CA, it is difficult to accurately estimate disclosure rates of various forms of CA, as most of the existing research tends to focus on childhood sexual and physical abuse and neglect. However, there is an understanding that disclosing traumatic past experiences may have therapeutic and physical benefits (Pennebaker et al., 1988), and may reduce distress in individuals (Paine and Hansen, 2002). Disclosure of experiences may also allow for emotional processing of a traumatic event that elicits fear, which is considered a crucial step in recovery from instances of trauma and PTSD (Foa and Kozak, 1986). However, it is important to note that the process of disclosure is not unilateral, but rather involves exchanges between the individual and their environment (Alaggia et al., 2017), meaning that both interpersonal and complex social and cultural influences may impact the process of disclosure. Disclosure itself may be accidental, purposeful, or elicited by others (Alaggia, 2004).

There are several factors that may impact an individual's ability to disclose negative experiences. Firstly, the fragmentary, disorganised nature of traumatic memory may mean that an individual is unable to recall aspects of the memory as it is not accessible to the conscious mind, but rather as flashbacks or painful sensory experiences and emotions (Herman, 1992). Furthermore, avoidance of such painful intrusions to protect oneself from re-experiencing can result in difficulty in disclosing such experiences (Busch and McNamara, 2020). Research on disclosure of childhood sexual abuse has indicated factors such as gender, age, relationship to perpetrators of abuse, and fear of not being believed, as potential barriers to disclosure (O'Leary and Barber, 2008; McElvaney et al., 2020; Ullman, 2007). Individuals who wish to disclose their experiences may also fear/experience shame, social taboo, and the feeling of not wanting to bother others with their painful experiences (Busch and McNamara, 2020). Individuals with experience of childhood sexual abuse have reported that they chose to disclose to protect others from abuse, because they could not bear the abuse continuing any longer, and as a form of seeking justice (Allnock and Miller., 2013). In cases of intrafamilial abuse, delays in disclosure may have resulted due to loyalty to the perpetrator, and worries concerning the impact and consequences of disclosing to the family (London et al., 2008).

1.5.2. The process of disclosure

A review of existing research pertaining to disclosure (not specifically to MHP's) used thematic analysis to extrapolate key themes regarding facilitators and barriers to disclosure of childhood sexual abuse (Alaggia et al., 2017). The review highlighted that the process of disclosure is not a discrete, linear event, but rather an iterative and interactive process, that is influenced by both internal and external processes (individual, relational, familial, community, cultural and societal). The review also found that an individual's age and gender can significantly influence disclosure. Notably, the review found that the identification of barriers to disclosure exceeds that of identification of facilitators. The review concluded that further research is required to understand and explore the influence of environment, context, and culture on disclosure.

1.6. Systematic Literature Review: What are the Barriers and Facilitators to Disclosing Childhood Adversity to Mental Health Professionals?

1.6.1. Objective

Existing research predominantly explores disclosure relating to childhood abuse and neglect, from the perspective of the MHP. As such, the objective of the following systematic review was to identify literature relating to barriers and facilitators to disclosure of CA (in addition to childhood abuse and neglect), from the perspective of the individual. A systematic review allows the researcher to systematically search, critically appraise, and produce a synthesis of existing research surrounding a predetermined topic (Ganeshkumar & Gopalakrishnan, 2013). Therefore, a systematic review was conducted, with the aim of identifying existing literature to answer the question: what are the barriers and facilitators to disclosing CA to MHPs?

1.6.2. Inclusion criteria:

Inclusion criteria were determined to allow for the selection of relevant papers. Inclusion criteria were selected regarding participants, study design, and study outcomes.

1.6.2.1. *Participants:* Studies were to be included if they used participants aged 18 or above, who had experienced some form of CA in childhood and had disclosed or attempted to disclose (including failure to disclose) their experiences in adulthood, to an MHP.

1.6.2.2. *Study design:* Studies were to be included in the review if they utilised quantitative and/or qualitative designs.

1.6.2.3. *Study outcomes:* Studies were included if they explored disclosure experiences of individuals, and possible barriers and/or facilitators to disclosing to MHPs.

1.6.3. Exclusion criteria:

Exclusion criteria were also considered prior to the literature search. Exclusion criteria regarded who disclosed, and timing of adversity experience.

1.6.3.1. *Who disclosed:* Studies were to be excluded if they were exploring the experiences of MHPs reporting their clients' experiences (e.g., to authorities), or if the study explored parents reporting their children's experiences.

1.6.3.2. *Timing of adversity:* Studies were to be excluded if they were exploring individuals who had disclosed experiences of adversity that occurred in adulthood, rather than childhood.

1.6.4. Search Strategy:

To identify potentially relevant literature, a systematic electronic database searches were conducted using PsychInfo, and MEDLINE (PubMed), from the earliest record to November 2023. The database searches were limited to research articles and dissertations, and to the English language. The search terms that were used in the systematic review were identified and adapted from two existing systematic reviews. A previous systematic review exploring the barriers and facilitators to disclosure of sexual abuse in children and adolescents (LeMaigre et al., 2017) was used to identify appropriate search terms relating to barriers and facilitators of disclosure, which were then adapted for the specific systematic review topic. Similarly, a systematic review exploring measures of CA and cardiovascular health life course (Appleton et al., 2017), supported the identification and adaption of search terms relating to CA.

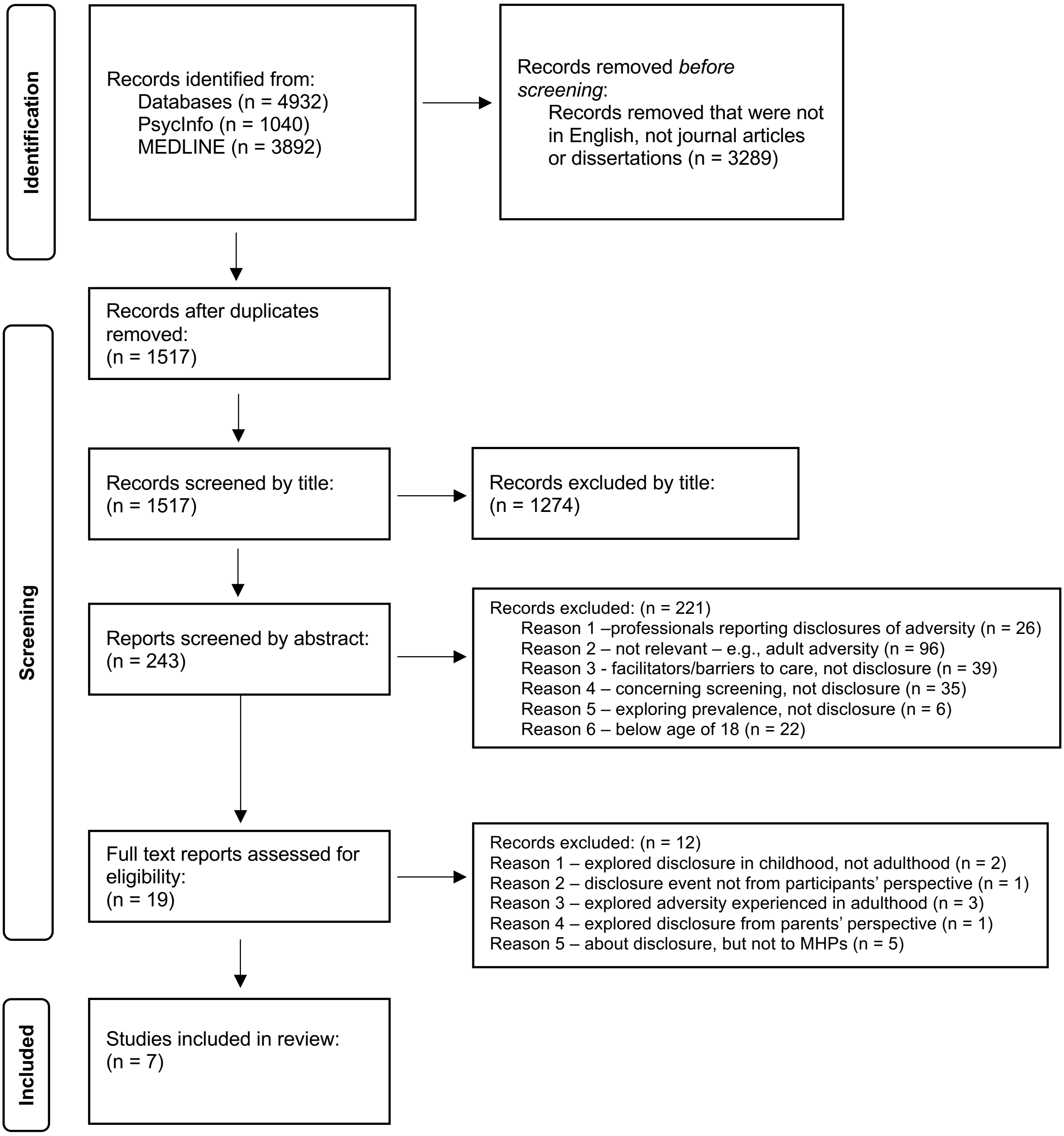
The final search string used in the electronic database search was: (barrier* OR inhibit* OR stop* OR withhold* OR facilitat* OR motivat* OR enabl* OR support* OR help*) AND (disclos* OR nondisclose OR nondisclosure OR tell* OR "help seek*" OR report*) AND ("child* adversity" OR "adverse experiences" OR "adverse childhood experiences" OR "child* maltreatment" OR "child* neglect" OR "child* abuse" OR "sexual abuse" OR incest OR ACEs OR "child* poverty" OR "physical abuse" OR "emotional abuse" OR "child* trauma*") AND ("mental health professional" OR "mental health clinician" OR "mental health practitioner" OR psychotherapist OR "mental health nurse" OR "mental health service" OR "clinical psychologist" OR psychiatrist OR counsel* OR "psychiatric services" OR "mental health staff").

1.6.5. Review process

Figure 1 shows a PRISMA diagram of the systematic review, which depicts the flow of information through the systematic review process (Page et al, 2020). The initial electronic database search yielded a total of 4,932 records. Limiting records by language and type of article resulted in the exclusion of 3,289 records, due to a large number of records being from books and government policy documents. The screening portion of the review included 1,517 records, following removal of duplicate records. The researcher screened the remaining records firstly by title, including any article titles that appeared as though they may be addressing the barriers/facilitators of disclosing CA to MHPs. During title screening, 1,274 irrelevant records were excluded. The researcher then screened the remaining 243 records by abstract, of which 221 records were excluded, for reasons such as a lack of relevance to the review question, not exploring disclosure (but rather prevalence, screening, and barriers/facilitators to care), or reporting on participants below the age of 18.

The researcher then read the remaining 19 studies in full and excluded 12 (see Figure 1). Five studies were excluded because they were about the disclosure of adversity to individuals/systems that were not MHPs. Three studies were excluded because they explored disclosure of adversity that was experienced in adulthood, rather than childhood. Two studies were excluded because they explored disclosure during childhood, not adulthood. One study was excluded because the disclosure event that was analysed was not from the perspective of the individual, and one study was excluded because it explored parental disclosure. The remaining seven studies were included in the review. A flow diagram of the identification and screening process is presented in Figure 1, in line with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (Page et al., 2020).

Figure 1. PRISMA Flow Systematic Review Diagram



1.7. Results of Systematic Review

1.7.1. Study Characteristics

A summary table (Table 1) of the seven included studies can be found in Appendix A. All the studies included in the review were of a qualitative nature, with a range of methods of analysis; grounded theory, thematic analysis, and interpretative phenomenological analysis (IPA). Of the seven studies, three were conducted in Canada (Alaggia, 2005; Collin-Vezina et al., 2015; Denov, 2003), two in the US (Smith, 2020; Sorsoli et al., 2008), one in Australia (O'Brien et al., 2007), and one in the UK (Moore et al., 2015). The age range was between 18 to 69 years. One study (O'Brien et al., 2007) did not report the age of the participants, only that they were adult females. Four of the studies included both males and females (Alaggia, 2005; Collin-Vezina et al., 2015; Denov, 2003; Moore et al., 2015), two recruited males exclusively (Smith, 2020; Sorsoli et al., 2008), and one recruited exclusively females (O'Brien et al., 2007). Across studies, 111 females, and 55 males were recruited; several studies reported a difficulty in accessing and recruiting males for their studies.

1.7.2. Type of Childhood Adversity

Regarding the type of CA explored, five studies referred solely to childhood sexual abuse (Alaggia, 2005; Collin-Vezina et al., 2015; Denov, 2003; Smith, 2020; Sorsoli et al., 2008). One study primarily explored experiences of childhood sexual abuse but mentioned that participants reported other forms of CA, such as physical and emotional neglect and abuse (O'Brien et al., 2007), and one of the studies explored experiences of institutional abuse in childhood (Moore et al., 2015). Throughout the systematic review process, it became clear that the majority of research undertaken in the area of CA and disclosure focuses on childhood sexual abuse, and that often other forms of abuse and neglect are not investigated, nor extricated from the primary focus of childhood sexual abuse, thus making it difficult to explore the potential differences of specific forms of CA and disclosure to MHPs, or the potential impact of the volume/severity of adversities experienced.

1.7.3. Barriers and facilitators to disclosure of childhood adversity to MHPs

The key findings relating to barriers and facilitators of disclosure of CA to MHPs are described below. Only one of the seven studies directly explored disclosures to MHPs (Denov, 2003), however, the other studies all reference disclosure to MHPs. Three of the studies include both barriers and facilitators to disclosure of CA (Denov, 2003; O'Brien et al., 2007; Smith, 2020), and four studies only attend to barriers (Alaggia, 2005; Collin-Vezina et al., 2015; Moore et al., 2015; Sorsoli et al., 2008). A summary of each study is provided below.

1.7.4. The seven studies

1.7.4.1. Alaggia (2005): The first study explored factors that impede or promote the disclosure of childhood sexual abuse, through qualitative analysis of interviews from 30 adults (19 females and 11 males) between the ages of 18 and 65, living in Canada. The study explored tactics used by perpetrators to suppress disclosure and their impact, and the individual, familial, and environmental factors that may influence disclosure. The study found that more than half of the sample delayed disclosure until adulthood. For those withholding disclosure, disclosure often occurred following a hospital admission or mental health crisis. The study highlighted that individuals found it difficult to put their experiences into words, with one participant finding art therapy a useful way to disclose what had happened without verbalising their experiences. Alaggia (2005) notes that despite similar trends in disclosure patterns between males and females, different influential factors arose specifically for each gender. Men (all of whom were abused by a male) described fears of being viewed as homosexual and of becoming a perpetrator of abuse themselves, in addition to difficulties disclosing due to prevailing attitudes in society surrounding masculinity, and homosexuality. Women, on the other hand, anticipated not being believed, and blamed, for their experiences of abuse, in addition to fears of being seen as a victim.

The Alaggia study represents an important exploration of the individual, social, and societal influences on disclosure of childhood sexual abuse.

The findings of the study hold important implications for mental health practitioners, highlighting that gender can impact disclosure of childhood sexual abuse, and that shame and fear experienced by victims needs to be acknowledged, validated, and worked through in a sensitive manner. One limitation of the study is the relatively limited sample size, despite participants being from a diverse socioeconomic status, which decreases generalizability to the wider population. The findings may not be relevant to disclosure of other childhood adversities, which were not explored in this study.

1.7.4.2. *Collin-Vezina et al. (2015):* This study, the largest of the seven, utilised a grounded theory approach to explore individual, relational, and social factors, that may inhibit disclosure of childhood sexual abuse. Interviews were conducted with 67 adults (16 males and 51 females), aged between 19-69, living in Canada, who had recently accessed counselling services. The study identified three broad themes of barriers to disclosure: barriers from within, barriers in relation to others, and barriers in relation to the social world. Participants highlighted their experiences of inner turmoil, internalized victim-blaming, and attempts to minimise the impact of abuse, consciously and unconsciously, through repression and denial. Participants described an inability to trust others in the aftermath of abuse. In addition, the young age at which some participants experienced abuse meant that their recollections of events, and incomplete comprehension of what happened, as a barrier to telling. Participants named power dynamics (containment of abuse within the family, in addition to fear of increased violence), and an awareness of the potential consequences of abuse was as barriers. Participants highlighted societal beliefs of stigma surrounding abuse, taboo relating to sexuality in society, and the lack of services (and lack of awareness of existing support services) as further impediments to disclosing.

This study highlights the process of disclosure as a complex, multi-level process that can be influenced not only by an individual's experiences and beliefs, but by societal beliefs and cultural norms. However, the study failed to explore participants experiences of facilitating factors. Most of the participant sample were between the ages of 40-49, female, and Western Caucasian, suggesting limited transferability to the general population.

1.7.4.3. Denov (2003): Denov (2003) explored the disclosure experiences of 14 victims (aged 23-59) of sexual abuse by females to professionals in Canada, and the impact of the professional's response on the victim. The study used semi-structured interviews and applied a qualitative approach to data analysis. All participants reported disclosure to a professional, with the aim of accessing counselling and support. 93% of participants disclosed abuse whilst accessing therapy, with one participant disclosing as a child. The study reported 12 participants as experiencing positive professional responses to disclosures, with two key themes: a supportive and understanding stance, and taking the disclosure seriously, without doubt. Eight victims reported experiencing negative responses, with three key themes: professionals showing discomfort and resistance to disclosure, minimisation of abusive acts that were disclosed, and professional's shock and disbelief. Those who experienced positive responses noted experiencing relief and reassurance, and contribution to healing. One participant reported that positive response did not impact theme. Those who experienced negative responses reported feelings of distrust, betrayal, anger, and participants subsequently questioning and denying the abuse.

The findings highlight the potential impact of professional's responses to disclosure on the wellbeing of victims and highlights the importance of professional sensitivity and support when responding to disclosures of sexual abuse. A limitation of the study is that it did not explore participant's reasoning for disclosure, other than stating that participants sought psychological support. The generalisability of the study is low due to the small sample size, and the study did not enquire about other forms of adversity. The study also acknowledges that victims of abuse with negative experiences of disclosure may have chosen not to seek further psychological support due to their negative experiences, and were therefore excluded from the study, as participants were recruited through referrals from professionals.

1.7.4.4. Moore et al. (2015): This study explored the help-seeking experiences of 22 Irish emigrant survivors of institutional abuse (aged 53-67), using thematic analysis. The study explored a range of influencing factors that encouraged help-seeking, and reported that victims disclosed to professionals, such as psychologists and solicitors, to seek financial aid, or to 'tell their story', rather than to intentionally seek help for psychological problems. Participants shared a range of self-management strategies (e.g., prioritising needs of family and children) that delayed or prevented help-seeking. Some participants reported seeking help from parents, schools, and authorities, but were ignored and repressed. Participants also reported being able to conceal details of abuse, as they were not directly asked in the UK. Participants reported accessing service-user led support services and survivor-led groups as encouraging a level of disclosure that they would not offer to the 'most trusted professionals' and noted that victims highlighted the lack of understanding from helping professionals regarding the extent and horrific realities of institutional abuse. Participants also highlighted difficulties in seeking support due to their underdeveloped numeracy and literacy skills.

The study highlights the specificity of individual's help seeking experiences for institutional abuse, and the importance of a need for greater understanding of how specific forms of adversity can impact help-seeking and disclosure. The study also highlights several barriers (self-management, educational disadvantage, repression of disclosure) and facilitators (survivor-led support groups, telling their story) to disclosure and help-seeking. A limitation of the study is the sample population; males were underrepresented within the sample (2 participants), and were mostly recruited from service providers, meaning that those not yet seeking help were not included in the study. The study also acknowledged that the methodology used (thematic analysis) meant that some themes arising within the sample were not examined across the whole sample.

1.7.4.5. *O'Brien et al. (2017):* This study explored the experiences of 14 female survivors of childhood sexual abuse in Australia, and their experiences of accessing and utilising non-profit organisations. A qualitative thematic design was used, and data was collected via focus groups and individual interviews. Every participant highlighted experiencing minimisation of the impact of childhood sexual abuse from professionals, including a belief that there was no link between abuse and mental health difficulties. Participants said they were not asked about abuse in childhood, despite sharing problems that could be indicative of trauma. Some participants highlighted positive experiences in specialist childhood sexual abuse services, in which professionals, listened, did not judge, and did not question participants about their experiences. Participants expressed difficulties accessing specialist services and found that lack of access to long-term counselling was dissatisfying, due to difficulties establishing a trusting therapeutic relationship. Participants highlighted the importance of dealing with practical issues (drug and alcohol difficulties) before being able to engage in therapeutic work and establishing boundaries in therapy. Participants highlighted long waiting lists, feeling rushed, and failure of therapists to understand the impact of abuse.

The study highlighted the variation in experiences of accessing psychological support for childhood sexual abuse, and the barriers and facilitators of disclosing abuse to MHPs. The study also highlighted the complexity of the problems experienced by survivors, and how this may be misunderstood and minimised by professionals. The generalisability of the study is low, due to the small sample size and lack of males in the sample. The study also failed to explore other experiences of CA.

1.7.4.6. *Smith (2020):* The smallest of the seven studies explored the experiences of three male survivors (aged 48, 54, and 67) of childhood sexual abuse in the US, using interpretative phenomenological analysis. Data was collected via semi-structured, in person interviews. The study identified four themes: the theme ‘alone and not alone’ highlighted that connection with other victims facilitated disclosure to MHPs. The theme ‘throwing grenades’ highlighted participants experiences of discomfort from professionals when they disclosed their experiences. The theme ‘monsters in the deep’ described participants feelings that the abuse had become its own entity, and that the desire to distance from the monster encouraged disclosure. The theme ‘that’s not what I wanted’ highlighted participants experience of professionals guiding the conversation away from their disclosures and suggesting confrontation of the abuser. Participants also highlighted the stigma of childhood sexual abuse as a barrier to disclosure.

This study facilitated an in-depth exploration of the disclosure experiences of three male survivors of childhood sexual abuse and indicated the barriers and facilitators of disclosure that the participants experienced. Due to the homogenous nature of the sample (age, gender, ethnicity), the study lacks generalisability, and did not explore experiences of female survivors.

1.7.4.7. *Sorsoli et al. (2008):* This study explored the challenges surrounding disclosure for 16 male survivors of childhood sexual abuse in the US, aged 24-61 years. The study was qualitative and used grounded theory. The data was collected via semi-structured interviews. The study identified three levels of disclosure barriers: personal, relational, and sociocultural. Personal barriers were described as cognitive awareness of the abuse, intentional avoidance of disclosure due to the difficulty in approaching the topic, difficulties articulating their experiences, emotional readiness, lack of safety, and experiences of shame. At the relational level, participants highlighted fears of negative repercussions of disclosure, in addition to anticipated disruption to relationships with others, and isolation. At the sociocultural level, participants highlighted the stigma surrounding childhood sexual abuse, and abstract social rules about what was normal for males to experience.

This study highlighted a range of barriers that are experienced at personal, relational, and sociocultural levels when considering disclosure of childhood sexual abuse to MHPs, and others, such as family members. The study reported difficulties in recruiting males to the study and concluded that those participating in the study were ‘quite unusual in their ability to speak about their abuse’ (pp. 342). The study was also not initially focused on disclosure, which suggests that questions included in interviews may not have explored disclosure in depth. A such, facilitators to disclosure were not identified in the study.

1.7.5. Summary of Findings

To summarise, the main barriers to disclosure of CA to MHPs were:

1. Barriers related to an individual’s beliefs and experiences (namely being too young or lacking cognitive awareness that what they were experiencing was CA; experiences of shame and difficulty articulating their experiences; and the implementation of self-management techniques in response to the distress that results from acceptance and understanding of CA and the impact it has had on them).

2. Barriers in relation to others (a fear that MHPs and others may not believe them when they disclose, which was notably impacted when individuals experienced adversity from perpetrators of certain genders; and anticipation

of responses from MHPs, e.g., MHPs appearing shocked, uncomfortable, or disbelieving of an individual's disclosed experiences).

3. Barriers in relation to the social world (the influence of labelling, attitudes and social stigma surrounding experiences of abuse and adversity within MHPs and the general population; a lack of understanding by MHPs about the extent of abuse occurring and the impact of lesser known/understood adversities on an individual; and the accessibility of services, including barriers that stopped individuals from accessing services (substance use, long waiting lists)).

The main facilitators to disclosure of CA to MHPs were:

1. MHPs' responses during the disclosure process (holding a supportive, non-blaming, and understanding stance, in addition to taking the disclosure seriously).

2. Access to support and the opportunity to build a trusting, therapeutic relationship with MHPs (including the connection that is felt between the disclosing individual and MHP as a disclosure occurs; and access to long-term therapy that allows a trusting relationship to be built over time).

3. Connections with other individuals who have also experienced CA (encouragement to seek support and direction regarding accessible services).

1.8. Gaps in Existing Literature

Based on the findings of the systematic review, it appears that there is a general understanding of the barriers to disclosing certain forms of CA, such as childhood sexual abuse and neglect, but that this research is limited and cannot be extrapolated to other forms of CA, as studies do not disentangle other forms of CA from the primary focus of childhood sexual abuse and neglect. Similarly, research has explored barriers to disclosure from an individual perspective, namely concerning how one's beliefs and experiences may act as a barrier to disclosure, in addition to the processes that occur during disclosure (e.g., MHPs potential responses and understanding of the impact of abuse and neglect). Nonetheless, researchers have called for further exploration regarding the influence of environment, context, and culture on disclosure (Alaggia et al., 2017). In addition, it appears that most existing research fails to explore the facilitators of disclosing traumatic experiences to MHPs, when compared with research exploring barriers to disclosure. There is also the potential for further research exploring the impact of age and gender of the process of disclosure. Most studies struggled to recruit male participants, suggesting that there may be further barriers that are yet unexplored within the male population. Similarly, there does not appear to be any research exploring survivors' experiences of being asked, or not being asked, about CA.

1.9. Rationale and Research Aims

To my knowledge, no existing study has attempted to explore individuals' experiences of disclosing (or not disclosing) experiences of CA to MHPs. The nature of the current research allows exploration of the facilitators and barriers to disclosing, from the perspective of the individual. In addition, current trends within existing research and the primary focus of disclosure of childhood sexual abuse means that currently, there is little understanding of the process of disclosure of many other forms of CA, such as poverty, bullying, discrimination, to name but a few. In addition, there appears to be no existing research pertaining to the experience of being asked, or not being asked, about CA by MHPs. The findings of the current research may contribute to initiatives to reduce the barriers that individuals face when attempting to disclose to MHPs, but also to identify facilitating factors that may make the process of disclosure more likely.

The knowledge that early life circumstances, and distressing experiences in childhood, later contribute to significant difficulties across the lifespan (Johnstone et al., 2018), suggests that it is imperative for early identification and provision of support from supporting services, and MHPs. Similarly, the knowledge that, if not asked, it can take approximately 9-16 years for someone to disclose distressing experiences in childhood (Read et al., 2006), suggests that it is crucial for MHPs to enquire about experiences of CA. If MHPs have a greater understanding of the barriers and facilitators to disclosure, they may feel more able, and place greater importance on enquiring about CA. Therefore, the current research may be fundamental in contributing to the implementation of routine enquiry, trauma-informed training for MHPs, and increased awareness of how the barriers to disclosure can be reduced, and the facilitators to disclosure can be implemented, thus resulting in earlier identification and intervention.

The distinct lack of research concerning the barriers and facilitators of disclosing experiences of CA to MHPs suggests that further exploration is warranted. The current research aims to explore, from the individual's perspective rather than that of MHPs, the barriers, and facilitators that they have faced when attempting to disclose experiences of CA to MHPs. The current research is designed to contribute to existing research that explores experiences of disclosing childhood sexual abuse and neglect by enquiring about experiences of individuals who have histories of a range of different childhood adversities. It was hoped that the anonymous nature of the current research would enable access to populations that have previously been difficult to access. It is hoped that the current research will enable a greater understanding of the process of disclosure, and further inform MHPs and supporting services to ensure trauma-informed care.

1.10. Research Questions

Therefore, the research questions are:

1. What do individuals report facilitated disclosure of CA to mental health professionals?

2. What are the barriers that individuals with experience of CA face when disclosing their experience to mental health professionals?

3. What were individuals' experiences of being asked, or not being asked, about their experiences of CA?

2. METHODOLOGY

2.1. Epistemology and reflexivity

The exploration of a researcher’s ontological-epistemological position enables explicit understanding and awareness of one’s (initially implicit) assumptions about what it means to know something (ontology) and how we come to know what we know (epistemology). Ontological-epistemological positioning can influence which, and how, research questions are asked, and how research findings are understood and interpreted (Willig, 2023). Similarly, ontological, and epistemological assumptions are foundational, guiding and informing methodological choices in research, and shape the researcher’s conceptualisation of participants and communication between them (Carter and Little, 2007). Thus, the development of ontological and epistemological reflexivity in research allows the researcher to consider how their fundamental assumptions about human beings (ontology) and their beliefs regarding sense-making of participants and the meaning of their experiences (epistemology) inevitably influence the interpretation and analysis of data (Willig, 2018).

The current research will be conducted in alignment with a critical realist epistemological position. Critical realism posits that there is a real world in existence, independent of our knowledge of the world (Bhaskar, 2014). A critical realist approach assumes a ‘realist’ ontology, combined with a ‘relativist’ epistemology (Archer et al., 1998). “A critical realist approach does not assume that the data directly reflect reality (like a mirror image); rather, the data need to be interpreted to provide access to the underlying structures that generate the manifestations that constitute the data” (Willig et al., 2023, p. 14). Therefore, the position suggests that our perception of the real world and real processes are influenced by context, acknowledging that ‘true’ reality cannot be uncovered due to subjective perceptions (Braun and Clarke, 2022).

A critical realist position is therefore in line with the current research, which assumes that there is a real world in which individuals with a history of CA face barriers and facilitators to disclosing their experiences to MHPs, but that this is influenced by a range of factors that are unique to an individual and their experiences. The research questions are therefore of an exploratory nature and seek to discover the processes that may impact disclosure to MHPs. Whilst the current research assumes that there are influencing factors, as identified by previous research, the topic of disclosure, relating to disclosure of CA to MHPs and influencing factors, is under researched, hence the open-ended nature of the research questions. A critical realist position is also in line with a social constructionist position, which assumes that reality is moderated by societal norms, culture, language, and history. Therefore, multiple perspectives of that reality are possible based on an individual's personal experiences (Burr, 2015), which will subsequently influence the way a participant interprets questions that are asked.

A critical realist position also accounts for the researcher's own personal context, experiences, and expectations of what the findings may suggest, and that this will impact the way that the findings are understood and interpreted, despite the critical realist objective of attempting to uncover the objective reality as much as possible (Howitt and Cramer, 2011). A researcher's position and experience will inevitably influence the questionnaire included in the study, in addition to the open-ended questions that have been developed. Therefore, researcher reflexivity is a crucial aspect of holding a critical realist position. Exploration and maintenance of personal reflexivity allows for greater understanding of how inter-subjective constructs may impact data collection and analysis, with the aim of ensuring that data analysis is less biased and transparent (Finlay, 2002). To maintain consistency in personal reflexivity throughout the research process, the researcher regularly used a reflective journal, with the aim of maintaining a reflective space in which to consider how the researcher's positioning and perspective shaped and impacted the research. As such, the following reflections surrounding the researcher's identity and position arose:

My personal position in the current study is that of a white, middle-working class, British, female, trainee clinical psychologist in her mid-twenties, with experience of CA and experience working in trauma services that promote a trauma-informed approach to care. As a trainee clinical psychologist at the University of East London (UEL), the researcher acknowledges that her understanding of distress is influenced by the social constructionist positioning of the training offered, which emphasises the role of social context in defining and understanding psychological distress. The researcher will explore the potential influence of their positioning and experience in the Discussion section (4.9. Reflexivity, pp. 96)

2.2. Design

Data was collected via an online survey, created using Qualtrics, an online survey tool. The study used a non-experimental qualitative approach. Demographic data collected via the survey was analysed using descriptive statistics. The qualitative data, and responses to open questions, were analysed using content analysis.

2.2.1. Descriptive Data

Descriptive data was collected at the beginning of the online survey, through use of closed questions relating to demographics and whether the participant had experienced CA. Likert-scale questions were also used at the end of the survey.

2.2.2. Qualitative Design

Qualitative data was also collected via the online survey and consisted of open questions that allowed participants to write as little or as much as they liked in response to questions about their experiences of disclosure of CA to MHPs.

2.3. Participants

Participants were recruited via opportunity sampling. Participants were not offered any incentive to take part in the study at any stage of the research process.

A research advertisement (see Appendix B) was created that highlighted the aims of the study, the inclusion criteria, and provided a definition of CA. The researcher contacted three organisations that support survivors of childhood abuse and trauma, who agreed to share the advertisement on their social media platforms. The researcher also shared the advertisement via three popular social media platforms (Facebook, Instagram, and Twitter).

The inclusion criteria were as follows:

- Between the ages of 18 and 40.
- Living in the UK
- Experience of CA
- Has sought help from mental health professionals in the last 20 years.

Participants were excluded from the research if they did not meet the inclusion criteria (see above). The design of the survey ensured that if the participant did not agree to take part in the survey, and/or did not meet the inclusion criteria, they were unable to complete the remainder of the survey.

The final data analysis consisted of responses from 96 participants. Participants were given the option of withdrawing their responses from the data analysis if they contacted the researcher within three weeks of completing the survey. None did so. As the advertisement was shared to an unknown number of people, and because there was not a countable population, it is not possible to estimate a response rate.

2.4. Measures

Qualtrics software was used to create the anonymous online survey (Appendix C). The survey was distributed by sharing the research advertisement. A link to the survey and a QR code were included on the advertisement.

The first section of the survey consisted of a participant information sheet (See Appendix C), a consent form with 11 (yes/no) questions, and a demographics section composed of 12 questions. If a participant did not consent to the study, a refusal message was displayed stating that they did not give consent to complete the survey. Similarly, if the participant did not meet the inclusion criteria, a refusal message stating that they did not meet the requirements for the study was displayed.

The main body of the survey consisted of the Expanded ACE Questionnaire (Cronholm et al., 2015). Within this section of the survey, participants were required to answer 23 closed questions. The Expanded ACE Questionnaire was selected for use within the online survey based on previous research highlighting the underrepresentation of the prevalence of types of adversity, such as those experienced at a community level, within specific population groups (Finklehor et al., 2013; Cronholm et al., 2015).

The Expanded ACE Questionnaire consists of the Conventional ACEs scale initially used by Felitti et al. (1998), that measures the following childhood experiences: emotional, physical, and sexual abuse, emotional and physical neglect, domestic violence, parental separation, household substance abuse, household mental health difficulties, and having an incarcerated family member. In addition, the Expanded ACE subscale consists of six further questions that measure an individual's experiences within their community: witnessing violence in the community, experience of discrimination due to race or ethnicity, experience of safety in the neighbourhood, experiences of bullying, and living in foster care. The final question within this section asked participants if they had ever told mental health professionals about their experiences of CA.

Following the Expanded ACEs questionnaire section, the survey branched off to two different lines of questioning, dependent upon the participants' response to 'have you ever told mental health professionals about your experiences of CA?'. Within this section of the online survey, participants were asked about their experiences of disclosing or not disclosing their experiences of CA to MHPs. The open-ended questions were developed through consultation with the research supervisor, and in consideration of the research questions. The open questions sought to explore:

- What participants found helpful and/or unhelpful during the process of sharing their experiences (open question)
- Whether the participant faced any barriers to disclosure and whether they felt that anything could have been done differently by the MHP (open question)

- If participants were asked by MHPs about experiences of CA, and how participants felt about being asked, or not asked (open question)
- Whether the MHP asked in a sensitive manner, if the MHP's response was helpful, if the MHP listened to, and acknowledged what the participant was saying, and if the participant was satisfied with how the mental health service responded to disclosures of CA (likert-scale questions)
- If participants felt that they received the help that they needed from MHPs/the mental health service (likert-scale question).

2.5. Procedure

2.5.1. Ethical Approval

Ethical approval was sought (See Appendix D) and granted from the UEL School of Psychology Ethics Committee (See Appendix E). An ethics amendment form was submitted and approved during the recruitment process to allow for the advertisement to be published on social media platforms (See Appendix F). The British Psychological Society's (BPS) Code of Human Research Ethics (Oates et al., 2021), was referred to during the process of seeking ethical approval and creating the study.

2.5.2. Informed Consent

Before answering the survey questions, participants were provided, as the opening pages of the online survey, with a participant information sheet (PIS) (See Appendix C) that detailed the purpose of the research, what participation would entail (completion of an online survey), their right to withdraw from the study, how their information and data would be used, stored, and protected, and that no identifying information would be collected. The researcher and research supervisor's email were provided within the PIS, should participants have any questions about the study prior to completing it. To progress to the online survey, participants were required to confirm that they had read the PIS and gave consent to take part. At the end of the online survey, participants were presented with a debrief sheet (See Appendix C), reminding participants of how their data will be managed, what will happen to the results of the research, and contact details of the researcher and research supervisor.

2.5.3. Potential Distress

Due to the nature of the topic being explored, and the potential for answering questions related to stressful past experiences being distressing for participants, a list of national support organisations and their contact details were included on the PIS for participants to refer to. The PIS and consent form specified a participant's right to withdraw at any time during the online survey, in addition to information regarding their rights to withdraw their data from the study following completion. At the start of the open questions in the online survey, participants were instructed to write as little or as much as they would like, enabling participants to provide as much detail as they felt comfortable with.

2.5.4. Online Survey

The online survey (see Appendix C) was disseminated via a recruitment advertisement (See Appendix B), which included an anonymous website link to the study and a QR code. Participants were allocated a random ID number that allowed for data to be collected anonymously. Participants were able to provide their ID number if they wished to withdraw their information following submission of their responses.

Throughout the process of analysing data, data was stored, as detailed on the PIS, in accordance with the Data Protection Act (1998). Initially, survey responses were stored within the Qualtrics program. Once the online survey was closed to new responses, data was exported to a password protected Excel spreadsheet. Data was then screened to remove any participants that did not meet the inclusion criteria. The final collected data was then exported to the Statistical Package for the Social Sciences (SPSS), allowing for a range of descriptive and inferential statistical analyses to be completed (see results section). Following analysis, data was stored on a password protected device so that data could be accessed for publication if necessary and will be destroyed after three years.

2.5.5. Data Analysis

Analysis of quantitative data (participants' age, gender, location, type of therapy (inpatient/outpatient), and length of time engaged with services, was analysed using SPSS (Statistical Package for the Social Sciences) to produce descriptive statistics. After data collection, data from participants who failed to complete the survey, or who did not meet the inclusion criteria, was removed from the dataset. Additional inferential statistical analysis was completed to explore possible interactions between demographic variables. Due to previous research suggesting that individuals of older ages are less likely to be asked about experiences of abuse (Cavanagh et al., 2004; Read et al., 2017), the hypothesis that this was the case for the current sample was tested using an independent-samples t-test was conducted to compare the mean age of those who were asked by mental health services if they had ever experienced CA, to the mean age of those who were not asked. Responses to open questions were analysed using qualitative content analysis.

2.5.6. Content Analysis

Qualitative data derived from the online survey was analysed using conventional content analysis. Content analysis is a qualitative research method that seeks to identify themes and patterns within from the content of textual data by using a systematic classification process of coding (Hsieh and Shannon, 2005). Conventional content analysis is a type of content analysis that is appropriate for research that seeks to explore a phenomenon, in this case, the experiences of individuals with CA. Researchers allow the textual data to provide categories and themes, rather than using preconceived categories (Kondracki, Wellman & Amundson, 2002). Inductive reasoning is used in qualitative content analysis, in which the researcher will examine and compare the raw data to directly derive coding categories. The decision to use conventional content analysis for this research was made due to the lack of research that has been undertaken on experiences of CA disclosure to MHPs, and due to the researcher's epistemological-ontological positioning; conventional content analysis is not informed by a specific framework or theory, but rather relies on the researcher's subjective interpretation of participants' unique experiences. Four separate content analyses were completed using the data. The first content analysis considered the facilitators of disclosing CA, the second content analysis considered the barriers of CA, the third content analysis considered experiences of being asked about CA, and the fourth content analysis considered experiences of not being asked about CA.

2.5.7. Content analysis process

The analytical process of content analysis followed seven key stages, as specified by Hsieh and Shannon (2005):

The researcher conducted the first two stages of the content analysis prior to collection of data: formulating the research questions and selecting the sample that was going to be analysed (participants' responses to the open-ended questions from the online survey).

In the third stage, the researcher began to define the categories to be applied during the content analysis. Firstly, the researcher familiarised themselves with the data, by repeatedly reading the data to immerse themself within the text, allowing consideration of the data as a whole (Tesch, 1990). As the researcher was using conventional content analysis, the researcher attempted to read the collected data without applying preconceived hypotheses to the content. This type of data immersion has been described as 'free-floating reading', where a researcher reads the data with an openness to the experiences that are reported without applying a theoretical framework or theory (Faria-Schützer et al., 2019).

The fourth stage involved outlining the coding process. The data was read word-for-word, and the researcher highlighted words within the text that appeared to specify key concepts or feelings, to develop initial units of meaning. Throughout this process, the researcher began to consider their initial impressions and analysis of the text, which, over time, allowed the researcher to develop an initial coding scheme, in which codes were created from initial units of meaning. New codes were generated when the researcher came across a particular word/thought that did not fit the existing codes.

The fifth stage of the analysis involved implementing the coding process. The reports were coded using the developed coding scheme. Due to the large number of responses and codes derived during the coding process for Content Analysis 1 and

2, the researcher included codes, to be sorted into subcategories and categories, that appeared in the data a minimum of five times. As there was less data to analyse for Content Analysis 3 and 4, the research included codes that appeared in the data a minimum of three times. The researcher then considered the data assigned to specific codes and sorted the codes into subcategories. Categories for the developed subcategories were then developed by the researcher.

To determine replicability and consistency of the analysis (the sixth stage), categories and subcategories were shared and considered with the research supervisor. The research supervisor was provided with a random sample of 12 quotes from Content Analysis 1 and Content Analysis 2, and 16 quotes from Content Analysis 3 and Content Analysis 4. The research supervisor coded them, blind, into the categories and subcategories developed by the researcher for each content analysis. The aim of blind coding the quotes was to explore the agreement between researcher and research supervisor about the developed categories, in order to establish whether there might be a need to refine subcategories and to identify potential changes that might be needed to ensure that categories and subcategories were discrete from each other.

For Content Analysis 1 (exploring facilitators of disclosure), there was agreement on 11 of the 12 (92%) random quotes assigned to their respective subcategories. For Content Analysis 2 (exploring barriers to disclosure), there was agreement on 10 of the 12 (83%) random quotes. After discussion of the reasons for the disagreements, a new subcategory was developed within the barriers content analysis, and definitions of two subcategories were further defined. For Content Analysis 3 (exploring experiences of being asked about CA), there was an agreement on 16 of the 16 (100%) random quotes, and for Content Analysis 4 (exploring experiences of not being asked about CA), there was an agreement on of 11 of the 15 (73%) quotes.

An example of the changes made following the review of categories and subcategories was the addition of the subcategory ‘perceived significance of CA’ to the ‘client experience’ category, after the research supervisor was unable to assign the following extract to a category: ‘I also wasn’t sure if my experiences were important enough to speak about'. The extract had initially been coded under the 'anxieties surrounding disclosure' subcategory. It was agreed that, due to the large frequency with which participants mentioned concerns about their experiences not being significant enough, that a discrete subcategory for those concerns was warranted. Upon discussion, two quotes were excluded from Content Analysis 4 due to not fitting any category or subcategory, and not meeting the minimum frequency criteria to form a new category.

The seventh stage, analysing the results of the coding process, will be described in the results section below.

3. RESULTS

This chapter describes the findings from the data analysis. A total of 130 participants attempted to complete the online survey, of which 34 were excluded for failing to meet the inclusion criteria. For example, 10 were excluded for their age, 10 for not living in Great Britain, two reported not experiencing CA, and 14 had not sought mental health support in the past 20 years. Two participants were excluded because of both their age, and not reporting experience of CA. The final analysis is comprised of the responses of 96 participants.

3.1. Demographic Data:

3.1.1. Participant Demographics

The demographics of the 96 participants that completed the online survey are summarised in Table 2.

The mean age was 27.5 years (SD = 5.44), and most were female (86.5%), and white (85.4%). Half of the participants attended college or university as their highest level of education (50%), followed by having completed a post-graduate degree (38.5%). Most participants were in full-time employment (59.4%). Regarding their experiences of mental health treatment, the majority were seen as an outpatient (76%), and the most common length of treatment was for over a year (37.5%).

Table 2. Participant Demographics

Demographic characteristics	Category	N (% of participants)
Age	18-23 years	25 (26%)
	24-29 years	43 (44.8%)
	30-35 years	17 (17.7%)
	36-40 years	11 (11.5%
Gender	Male	7 (7.3%)
	Female	83 (86.5%)
	Non-binary/third gender	4 (4.2%)
	Prefer to self-describe	1 (1%)
	Prefer not to say	1 (1%)
Ethnicity	Asian or Asian British	5 (5.2%)
	Black, Black British, Caribbean, or African	1 (1%)
	Mixed or multiple ethnic groups	4 (4.2%)
	Other ethnic group	3 (3.1%)
	White	82 (85.4%)
Education	Higher or secondary or further education (A-Levels, BTEC, etc)	9 (9.4%)
	College or University	48 (50%)
	Post-graduate degree	37 (38.5%)
	Prefer not to say	2 (2.1%)
Employment Status	Full-time	57 (59.4%)
	Part-time	13 (13.5%)
	Student	16 (16.7%)
	Unemployed	6 (6.3%)
	Other	3 (3.1%)
Mental Health Service	Inpatient	7 (7.3%)
	Outpatient	73 (76%)
	Other	4 (4.2%)
	Not sure	11 (11.5%)
Length of Treatment	Less than a month	10 (10.4%)
	Between one to six months	26 (27.1%)
	Between six months to a year	23 (24%)
	Over a year	36 (37.5%)

3.1.2. Number of people asked about experiences of CA:

A total of 82 (86.3%) participants answered the question ‘Did anyone from mental health services ever ask if you had experienced CA?’. 47 (57.3%) participants confirmed that they had been asked by a MHP if they had ever experienced CA, and 35 (42.6%) said they were not asked.

3.1.3. Likert scale responses regarding participants’ experiences of interactions with MHPs:

Participants who answered ‘yes’ to the question: ‘Did anyone from mental health services ever ask if you had experienced CA?’ were then presented with five Likert scale questions/statements.

43.5% agreed that they strongly agree with the statement ‘MHPs answered in a sensitive manner’. 39.1% reported that they strongly agreed with ‘The MHP/service listened to and acknowledged what I was saying’, and 37% reported that they strongly agree with ‘I was satisfied with how the service responded to me when sharing my experience of CA’. Regarding the statement ‘How helpful was the response from the MHP/service?’, the most frequent response was that they found the response helpful (23.9%).

Those who answered ‘no’ were presented exclusively with the statement ‘I got the help that I needed from the MHPs/ and the mental health service’. Those who answered ‘yes’ to the statement were also presented with this statement. 80 participants responded to this statement, with the most common response being that they somewhat agreed (35%). See Table 6 for a summary of the Likert scale responses.

Table 3. Likert-Scale Responses

Question	N (% of participants)						Total N who answered
	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree		
MHPs answered in a sensitive manner	2 (4.4)	2 (4.4)	6 (13)	16 (34.8)	20 (43.5)		46
The MHP/service listened to and acknowledged what I was saying	3 (6.5)	3 (6.5)	8 (17.4)	14 (30.4)	18 (39.1)		46
I was satisfied with how the service responded to me when sharing my experience of CA	5 (10.9)	8 (17.4)	6 (13)	10 (21.7)	17 (37)		46
I got the help that I needed from the MHPs/ and the mental health service	16 (20)	20 (25)	8 (10)	28 (35)	8 (10)		80
How helpful was the response from the MHP/service?	Not at all helpful	Somewhat unhelpful	Neither helpful nor unhelpful	Somewhat helpful	Helpful	Very helpful	
	2 (4.4)	9 (19.6)	6 (13)	9 (19.6)	11 (23.9)	9 (19.6)	46

3.1.4. Number of people who have disclosed their experiences of CA:

94 participants responded to the question ‘have you ever told MHPs about your experiences of CA?’, with 88 (93.6%) of participants responding yes, and seven (7.4%) answering no. Participants who did not disclose their experience of CA to MHPs were also asked ‘Did you want to tell mental health professionals about your experience of CA?’. Of the seven participants who had not disclosed their experiences of CA, three (42.9%) responded ‘yes’, and four (57.1%) responded ‘no’.

3.1.5. Being asked about Experiences of Childhood Adversity and Age:

The average age of participants who were asked about experiences of CA was lower (*M = 26.85, SD = 5.67*) than those who were not asked (*M = 28.97, SD = 5.4*). This difference was not significant using a two-sided t-test: *t* (80) =-1.71, *p* = .091.

3.2. Qualitative Results

The researcher completed four separate content analyses, the first exploring the facilitators to disclosure of CA to MHPs, the second exploring the barriers to disclosure of CA to MHPs, the third exploring experiences of being asked about CA, and the fourth exploring experiences of not being asked about CA. See Table 7 for a summary of the questions and corresponding content analyses. The first content analysis, that explored facilitators to disclosure, was undertaken using the data derived from responses to the question ‘What helped you to feel able to share your experience of CA?’. Data derived from responses to the question ‘Were there any barriers to telling the mental health professional about your experience of CA?’ were used for the second content analysis, that explored barriers to disclosure. The researcher also included responses from the questions ‘What was helpful and/or unhelpful during the process of telling the mental health professional about your experience of CA?’, and ‘Was there anything that could have been done differently by the mental health professional to help you to share your experience of CA?’, for the first and second content analyses.

The third content analysis, that explored experiences of being asked used the data derived from 45 participants who answered ‘yes’ to the question ‘did anyone from mental health services ever ask if you had experienced CA?’ and their responses to the subsequent question ‘How did you feel about being asked about CA?’. The fourth content analysis regarding experiences of not being asked about CA used data derived from 32 participants who responded ‘no’ to the question ‘did anyone from mental health services ever ask if you had experienced CA?’ and their responses to the subsequent question: ‘How did you feel when you were not asked about your experience of CA?’.

Table 4: Summary of Content Analysis and Corresponding Questions

Content Analysis	Corresponding Questions
Content Analysis 1: Facilitators to Disclosure	What helped you to feel able to share your experience of CA? What was helpful and/or unhelpful during the process of telling the mental health professional about your experience of CA?
Content Analysis 2: Barriers to Disclosure	Were there any barriers to telling the mental health professional about your experience of CA? What was helpful and/or unhelpful during the process of telling the mental health professional about your experience of CA?
Content Analysis 3: Being Asked about CA	How did you feel about being asked about CA?
Content Analysis 4: Not Being Asked about CA	How did you feel when you were not asked about your experience of CA?

3.2.1. Frequencies of Categories and Subcategories Included in Content Analyses

See Table 8 for the frequencies in which categories and subcategories were referred to within the data. The category most referred to in Content Analysis 1 was ‘MHP and Client Dynamics’ (64 times), and the category most referred to in Content Analysis 2 was ‘Influence of MHP’ (60 times). The category most referred to in Content Analysis 3 was ‘Emotions Experienced’ (30 times) and the category most referred to in Content Analysis 4 was ‘Negative Experience’ (13 times).

Table 5. Frequencies of Categories and Subcategories

Content analysis	Category	Frequency of category in data	Subcategory	Frequency of subcategory in data
1. **Facilitators**	MHP and Client Dynamics	64	Attunement	26
			Trauma Competence	28
			Therapeutic Relationship	10
	Client Motivation	21	Mental Health Decline	9
			Motivated Disclosure	12
	Environment	33	Safety	14
			Time	19
2. **Barriers**	Influence of MHP	60	MHP Demeanour	20
			Lack of Enquiry	7
			Negative Responses	33
	Client Experience	44	Impeded Ability to Disclose	16
			Anxieties Surrounding Disclosure	14
			Emotional Barriers	8
			Perceived Significance of CA	6
	Session Environment	53	Treatment Format	35
			Confidentiality	18
3. **Being Asked**	Emotions Experienced	30	Positive Emotions	15
			Negative Emotions	6
			Mixed Emotions	9
	Expectations of Being Asked	8	Expecting to be Asked	5
			Not Expecting to be Asked	3
4. **Not Being Asked**	Positive experience	3	Preference to Disclose by Themselves	3
	Negative Experience	13	Unable to Disclose by Themselves	3
			Invalidation and Disappointment	10
	Mixed/Neutral Experience	8	Neutrality	4
			Initial Response Shifting Over Time	4

3.2.2. Content Analysis 1: Facilitators to Disclosure

Three categories were derived from the data pertaining to the facilitators of disclosing CA to MHPs. The first category, ‘MHP and Client Dynamics’, consisted of three subcategories: *‘Attunement’*, ‘*Trauma Competence’*, and ‘*Therapeutic Relationship’*. The second category, ‘Client Motivation’, consisted of two subcategories: ‘*Mental Health Decline’* and ‘*Motivated Disclosur*e’, and the third category, ‘Environment’, consisted of two subcategories: ‘*Safety*’ and ‘*Time*’. See Table 9 for a summary of the categories and subcategories.

Table 6. Content Analysis 1: Facilitators to Disclosure

Category	Subcategory	Subcategory Definition
MHP and Client Dynamics	Attunement	MHP’s verbal and nonverbal communication to clients.
	Trauma Competence	MHP’s ability to ask questions about CA, to practice trauma-informed care, not shying away from discussing trauma.
	Therapeutic Relationship	The development of an open and trusting relationship between the MHP and the client.
Client Motivation	Mental Health Decline	Decline in mental health acting as a motivating factor to disclose experiences of CA to get appropriate support.
	Motivated Disclosure	Motivation to disclose to understand the impact of CA on mental health, and/or desire to get support and feel better.
Environment	Safety	Client’s perception of safety and confidentiality whilst engaging with MHP.
	Time	Timing of sessions, length of sessions, space to feel able to disclose.

3.2.3. Category 1: MHP and Client Dynamics

64 participants referred to several aspects of the dynamics and relational experiences with the MHP, that facilitated their ability to disclose experiences of CA.

3.2.3.1. *Attunement:* In response to being asked ‘What helped you to feel able to share your experience of CA?’ and ‘What was helpful during the process of telling the mental health professional about your experience of CA?’, 26 participants highlighted that their experiences of disclosure and willingness to disclose their experiences of CA were facilitated by positive verbal and non-verbal communication with their MHP.

“More recently I have shared more experiences and what helped was having a (private) therapist who actually understood me and listened.”

“My therapist was just comforting.”

“I found the validation of my feelings helpful, especially the phrase ‘You’ve done the right thing by coming here today’. It alleviated a lot of guilt I was feeling about my feelings.”

“They were understanding, non-judgemental, seemed curious, did not blame me, labelled what it was.”

“They listened.”

3.2.3.2. *Trauma Competence:* 28 participants reported that MHPs facilitated disclosure through asking direct questions about their experiences, in addition to having experience in working with trauma, and practising trauma-informed care. Participants highlighted that MHPs who were able to discuss traumatic experiences without shying away from disclosures encouraged open conversations about CA.

“They asked me direct questions after picking up on comments I had made.”

“It was helpful when they asked prompting questions about childhood and things like bullying.”

“It was helpful when the therapist asked me about my experiences in childhood and continued to ask questions about it after I mentioned my difficulties in childhood.”

“People being specifically trauma informed was helpful.”

“A female practitioner was able to hold what I had, she didn’t shy away or recoil.”

“Professionals using words like rape, sex, suicide, abuse as it gave me a language to use and knew they could "cope" hearing words like those.”

3.2.3.3. *Therapeutic Relationship:* 10 participants highlighted the importance of being able to build rapport, and having an established, open, and trusting relationship with their MHP as a facilitator to disclosing CA.

“After I had built a relationship with the professional and felt safe, not judged and that I could trust them.”

“A calm environment helped, an established good relationship with the mental health professional where they are non-reactive and didn’t press too hard for further answers.”

“I think it was approached well by not directly asking initially and able to build the therapeutic relationship initially to have the safe space to discuss this.”

> *"It also helped to have a relationship with the therapist first to ensure it was a safe place and I knew they would hold the space for me to talk it through and be empathic."*

> *"My psychologist seemed trustworthy. We had developed a good rapport over several sessions, and I felt I could open up without judgement."*

3.2.4. Category 2: Client Motivation

21 participants highlighted that they had an underlying motivation towards disclosing their experiences of CA to MHPs, such as struggling with the impact of their experiences on their mental health and disclosing their experiences to enable themselves to access the support to work through difficult childhood experiences.

3.2.4.1. *Mental Health Decline:* Nine participants reported feeling that they needed to disclose due to their poor mental health.

> *"I did not feel I had a choice as I was really struggling."*

> *"My own mental health was getting so poor and relationships with other people so bad that I felt I needed to explore it."*

> *"I knew that the experiences I faced when I was a child were having a huge impact on my mental health and I needed to share this to be able to get better."*

> *"I needed to share my experiences. I couldn't handle the weight of my memories alone anymore. I was always told to trust the NHS - I think anyone could've walked into the therapy office and told me they were a professional and I'd have unleashed everything I'd been keeping to myself."*

3.2.4.2. *Motivated Disclosure:* 12 participants highlighted that they were motivated to disclose as a way of processing their past experiences, to gain a deeper understanding of the impact of those experiences, and to begin healing. Participants also expressed that they felt it was important to disclose to ensure that they received the correct treatment.

“The idea that it would help me feel better.”

“I needed to process it in order to move past it and live a healthy life.”

“I was curious to explore how childhood adversity might have affected my long-term psychological well-being as an adult.”

“It felt like important context to any genuine help I would be able to receive.”

“I wanted to be honest to get the help I needed and to make sure that I was given treatment.”

“The fact that the issue I was looking for help with was directly related to my experiences in childhood - I also felt that I might not get the right help if I wasn’t honest about what I had experienced.”

3.2.5. Category 3: Environment

33 participants reported that a safe and confidential environment facilitated disclosure of CA to MHPs, in addition to having adequate time to feel able to openly share their experiences.

3.2.5.1. *4.2.5.1. Safety:* 14 participants shared that a confidential setting was an important factor in feeling able to share their experiences, in addition to experiencing feelings of safety whilst engaging with treatment.

“I knew what I told her wouldn’t get shared to anyone else that I knew so I could just tell her everything and not have someone at home question what I said.”

“Being in a safe space and knowing it wouldn't leave the room.”

“Feeling like I was in a safe and private space made it easier to relax and try to recall childhood events.”

“Being reassured I was safe. Always being asked for consent to share the disclosure with other members of the team. Not feeling interrogated. “

“Once I was 16, I visited therapy on my own without my parents, which made me feel comfortable to talk about my experience without them being present.”

3.2.5.2. *Time:* 19 participants highlighted that having adequate time to discuss experiences without pressure helped them to feel able to disclose.

“Being given the space and choice to share what I wanted to without any pressure. Also, the ability to talk for as long or as much as I wanted without being interrupted.”

“I think it helped having therapy for a long time because I felt more able to open up as I got to know the person I was seeing.”

“They were incredibly patient, and didn't push me to tell them anything, and when I was frustrated at not being able to the times I attempted but couldn't, they helped by making sure I knew there was no pressure, and we explored how talking about it felt or might feel.”

“Not being pressured to share and told that I could open up about whatever I wanted, when I felt ready to do so.”

“Allowing disclosure to happen at the rate I would like it to while still encouraging me to keep going.”

3.2.6. Content Analysis 2: Barriers to Disclosure Content Analysis

Three categories were derived from the data pertaining to the barriers of disclosing CA to MHPs. The first category, *‘Influence of MHP’*, consisted of three subcategories: ‘*MHP Demeanour’, ‘Lack of Enquiry’,* and *‘Negative Responses’*. The second category, *‘Client Experience’,* consisted of four subcategories: ‘Impeded Ability to Disclose’, *‘Anxieties Surrounding Disclosure’, ‘Emotional Barriers’,* and *‘Perceived Significance of CA’*, and the third category, ‘*Session Environment’*, consisted of two subcategories: *‘Treatment Format’* and *‘Confidentiality’*. See Table 10 for a summary of the categories and subcategories.

Table 7. Content Analysis 2: Barriers to Disclosure Content Analysis

Category	Subcategory	Subcategory Definition
Influence of MHP	MHP Demeanour	Negative perceptions of MHP demeanour, and/or connection with the MHP.
	Lack of Enquiry	Lack of enquiry and direct questioning about experiences of CA
	Negative Responses	MHP responses to clients during the process of disclosure, past negative experiences of disclosing
Client Experience	Impeded Ability to Disclose	Client experiencing physical and experiential difficulties processing memories, not having the words to disclose
	Anxieties Surrounding Disclosure	Client fears and anxieties during disclosure, the potential negative impact of disclosing
	Emotional Barriers	Client experiences of emotions during disclosure, such as guilt, shame, and embarrassment
	Perceived significance of CA	Client concerns about experiences of CA not being significant enough, not being bad enough
Session Environment	Treatment Format	The type of treatment, length of treatment, potential environmental barriers to disclosure
	Confidentiality	Client feeling unsafe to disclose, fears of confidentiality being breached.

3.2.7. Category 1: Influence of MHP

60 participants highlighted that in some circumstances the MHP acted as a barrier to their feeling able to disclose their experiences of CA, such as their demeanour, their lack of enquiring about CA, or negative responses to participants either in the past, or during the process of potentially disclosing.

3.2.7.1. *MHP Demeanour:* 20 participants recalled experiencing the MHP/s as dismissive, pitying, and not understanding, in addition to a lack of rapport being established, as a barrier to disclosing CA.

“They were not understanding, and I did not feel listened to. I felt the counsellor was only there for a pay check and not because they were actually interested.”

“The therapist seemed to be a bit detached. I would have preferred a deeper emotional involvement from the therapist.”

“With some professionals I got more pity than any meaningful help.”

“Lack of understanding or rapport with the professional, more specifically older male professionals who dismissed things.”

“Them trying to be ‘objective’ and cold made me not disclose.”

3.2.7.2. *Lack of Enquiry:* Seven participants highlighted that the MHP didn’t ask about experiences of CA.

“Never being asked.”

“Never being directly asked - I find it hard to start any conversation let alone one about my childhood.”

"I think had I been explicitly asked about my childhood or if I had been hit, shouted at or saw domestic violence I would have opened up sooner."

"I eventually disclosed childhood sexual abuse, wasn't asked any other questions about my childhood so haven't shared all experiences (e.g., domestic violence at home)."

"I didn't open up about abuse to a psychiatrist or CPN because it wasn't asked and the questions never allowed for the disclosure."

3.2.7.3. *Negative Responses:* 33 participants shared experiences of MHPs responding negatively to experiences that they had shared in the past acting as a barrier to telling another MHP, or negative responses from MHPs when attempting to disclose CA.

"One therapist insisted that I answer questions, which is something I struggle with precisely because of the abuse that happened in my childhood. When I wasn't able to answer her questions ("How does this make you feel?" "What were you afraid of?") she was visibly frustrated and ended the relationship."

"Unfortunately, some counsellors, in addition to family members, did not believe me when I told them about my experiences."

"Them forgetting about me disclosing that I'd been sexually abused and denying that they had forgotten, telling me I hadn't disclosed this before when I had."

"I remember that the MH professional told me that it was 'cliche' to assume that all my problems were as a result of my upbringing."

"The psychiatrist said things that were confusing. Something that stuck in my mind was when he asked, "Did you have an orgasm? Do you feel guilty for enjoying it?" I was so shocked and angry. Of course I didn't enjoy it. It was abuse."

3.2.8. Category 2: Client Experience

44 participants shared personal experiences of feeling unable to disclose, including not feeling able to process traumatic memories, not being able to find the words to disclose, experiences of anxiety related to disclosing and the potential impact, emotional barriers such as shame and embarrassment, and concern that their experiences were not significant enough to disclose.

3.2.8.1. Impeded Ability to Disclose: 16 participants shared that they felt unable to share their experiences of CA due to difficulties processing memories, and/or not having the words to disclose.

> *"My own resistance to acknowledge what had happened as I had normalised and dismissed the extent of the abuse."*
>
> *"I also don't really want to process those memories."*
>
> *"My own barriers of not feeling able to talk about some things that were traumatic for me."*
>
> *"When I was older the only barrier was just the actual difficulty of getting the words out emotionally and physically."*
>
> *"Not having the wording or knowing where to start or how to bring it up."*
>
> *"Not having the language."*

3.2.8.2. Anxieties Surrounding Disclosure: This subcategory included 14 responses surrounding fears and anxieties arising about disclosing and the potential impact on the self and others.

> *"Worries that if I spoke the true extent of how much it had affected me, a mental health act would be used against me"*

"Sometimes I was worried I might scare them with how I truly felt."

"Judgment. The parent who causes my trauma was very well respected in the community and it had been drilled into me that this was a very private, family thing to be dealing with. There was also a certain level of guilt that I felt that I'd allowed it to impact on me in this way."

"Fears of judgement, not being heard or accepted."

"Worries about what would happen to people abusing me and what would happen to me."

"Some fear of rejection/being laughed at/invalidated."

3.2.8.3. *Emotional Barriers:* This subcategory included eight participants' experiences of shame, embarrassment and guilt surrounding their experiences of CA.

"Internalised shame makes it difficult for me to share."

"I only told them small amounts and not necessarily the more serious stuff because of shame and guilt."

"Feeling embarrassed about talking about my experiences as it was something new and something that is hard to talk about."

"I felt embarrassed."

"Feelings of shame and guilt."

3.2.8.4. *Perceived Significance of CA:* Six participants expressed that they did not know whether their experiences were significant enough to warrant disclosing.

“Some worry that it wouldn’t be significant enough.”

“I also wasn’t sure if my experiences were important enough to speak about.”

“I felt like my struggles were lesser than other people and I was afraid to take up the very limited mental health resources / clog up already long waitlists.”

“I didn't feel like my childhood adversity was as bad as other peoples.”

3.2.9. Category 3: Session Environment

This category included 53 participants’ experiences of the session environment, including the type of treatment/format of the discussion with the MHP, and their experiences of the impact of confidentiality on disclosure.

3.2.9.1. Treatment Format: This subcategory includes 35 responses pertaining to the type and duration of treatment, in addition to environmental factors.

“Long waiting lists, short/cancelled appointments”

“I think the system is a mess to be honest. There's no time for professionals to see patients and when they do, even if they genuinely care, they have to rush you out the door so you don't feel listened to”

“Lack of time is a big barrier. You get allocated limited number of sessions which puts a huge amount of pressure on you to either push past your discomfort and confide in someone you’ve not had time to build a trust with, or not actually get anywhere because the whole time is spent building trust”

“My experience in CMHT always made me feel as though what happened to me was always “too serious” for “simple” trauma focused CBT but not bad enough for trauma specific services so I have been offered nothing.”

> *"The restriction on amount of sessions was so unhelpful because by the time I'd built enough of a rapport to feel safe opening up the sessions were finished. So nothing really helped because I never really got deep into the experience."*

> *"The sessions were virtual, and I think may have been more beneficial and more containing if they had been in person as it gives more space to reflect and build the relationship."*

3.2.9.2. *Confidentiality:* 18 participants shared that confidentiality breaches acted as a barrier to disclosing CA.

> *"I was never able to speak openly or freely about things whenever my parents were present."*

> *"The first few MHPs I met with were all identified by my mother, who was my primary abuser. They would not maintain confidentiality and often worsened my situation at home."*

> *"Straight off the bat they could have asked if I would like to be alone in the appointment without me having to ask my parents to leave."*

> *"I didn't feel safe."*

> *"I did not feel as though everything I said would be kept strictly confidential."*

3.2.10. Content Analysis 3: 'How did you feel about being asked about CA?'

The third content analysis exploring experiences of being asked about CA consisted of two categories. The first category 'Emotions Experienced' consisted of three subcategories: '*Positive Emotions'*, '*Negative Emotions'*, and '*Mixed Emotions'*. The second category 'Expectations of Being Asked' consisted of two subcategories: '*Expecting to be Asked'*, and 'N*ot Expecting to be Asked*'. See Table 11 for a summary of the categories and subcategories.

Table 8. Content Analysis 3: Being Asked about CA

Categories	Subcategories	Subcategory definition
Emotions Experienced	Positive Emotions	Feeling validated, seen, heard, and relieved when MHPs asked about CA
	Negative Emotions	Feeling uncomfortable, and nervous when asked about CA.
	Mixed Emotions	Experiencing both positive and negative feelings when asked about CA.
Expectations of Being Asked	Expecting to be Asked	Participants expecting/anticipating being asked about CA.
	Not Expecting to be Asked	Participants feeling shocked and/or confused that they had been asked about CA, not realising impact of CA

3.2.11. Category 1: Emotions Experienced

30 participants reported a range of positive, negative, and mixed emotions when they were asked about CA by MHPs.

3.2.11.1. Positive Emotions: 15 participants expressed positive emotions when asked about CA by MHPs, such as feeling validated, seen, heard, and relieved.

"Seen. After years of not being asked to 'dig deeper' over why things could be the way they are as an adult, rarely was I asked if childhood could have impacted it. Within the past year or so is the first time I'd been asked and delved deeper and felt like I could actually make progress."

"I felt seen, understood, validated."

"I felt like somebody was finally willing to listen to me and believe me."

"I felt heard and relieved that it was being asked about."

3.2.11.2. Negative Emotions: Six participants expressed negative emotions when asked about CA by MHPs, such as feeling uncomfortable and nervous.

"Fearful of opening up completely and being truly seen. Some ACEs bring up a lot of shame like being groomed by abusers."

"I feel nervous when taking about it as I'm worried the people I am mentioning will hear that I have been taking about them and make it a problem claiming I'm being dramatic."

"Uncomfortable talking about it sometimes."

3.2.11.3. Mixed Emotions: Nine participants expressed both positive and negative emotions when asked about CA by MHPS.

"Embarrassed to have to talk about it but glad that it was asked about."

"Uncomfortable but like they cared and tried to find out what was going on."

"I felt glad that someone asked if I had experienced bullying, but also a bit embarrassed to share my experiences. I was also not asked about other types of childhood adversity."

"It was a weird thing to consider because you don't often realise things until they're pointed out. It made me a bit uncomfortable but it did help."

3.2.12. Category 2: Expectations of Being Asked

Nine participants reported that they either expected to be asked about CA by MHPs, or that they experienced shock and confusion when asked about CA because they had not expected to be asked.

3.2.12.1. Expecting to be Asked: 5 participants described an expectation that they would be asked about CA by MHPs.

"I expected to be asked."

"I didn't feel much. I know a lot of adult trauma stems from childhood. I expected to be asked this question when in therapy."

"I expected it and don't recall feeling any strong emotion in response."

"As this was the main reason I was under the care of psychologists, I felt as though it was expected of me."

3.2.12.2. Not Expecting to be Asked: Three participants expressed that they felt shocked and confused when asked about CA by MHPs.

"Shocked at first but fine after."

"When I first heard the term I was a little confused and shocked. I guess I didn't realise childhood experiences and your home environment can have such a big impact on your mental health."

"At first I was shocked, because I didn't realise that what I went through wasn't normal. I denied a lot of things until I started talking about it, and realised that this is actually what I was going through."

3.2.13. Content Analysis 4: 'How did you feel when you were not asked about CA?'

The fourth content analysis exploring experiences of not being asked about CA consisted of three categories. The first category 'Positive Experience' consisted of one subcategory: '*Preference to Disclose by Themselves'*. The second category 'Negative Experience' consisted of two subcategories: '*Unable to Disclose by Themselves'*, and '*Invalidation and Disappointment'*. The third category '*Mixed/Neutral Experience'* consisted of two subcategories: '*Neutrality',* and '*Initial Response Over Time'*. See Table 12 for a summary of the categories and subcategories.

Table 9. Content Analysis 4: Not Being Asked about CA

Categories	Subcategories	Subcategory definition
Positive Experience	Preference to Disclose by Themselves	Participants highlighted a preference for not being directly asked and being able to disclose on their own terms
Negative Experience	Unable to Disclose by Themselves	Not feeling able to disclose CA or understand CA without being directly asked by MHPs
	Invalidation and Disappointment	Feeling let down, disappointed, and invalidated when they were not directly asked about CA
Mixed/Neutral Experience	Neutrality	Not having an overarching opinion or feeling about not being asked.
	Initial Response Shifting Over Time	Feeling neutral about not being asked initially but experiencing positive/negative emotions about not being asked in hindsight.

3.2.14. Category 1: Positive Experience

Three participants shared that they had a positive experience when they were not directly asked about CA by MHPs.

3.2.14.1. Preference to Disclose by Themselves: three participants highlighted a preference for not being directly asked and being able to disclose CA on their own terms.

> *"I think it's better to talk it out rather than ask directly. Directly asking is blunt and can make someone put their defences up. A relationship and trust needs to be built before discussing these topics openly so it's better to wait for conversation to go there naturally."*

> *"A direct question would have put me in a situation I wouldn't have been comfortable with. I probably would have lied or made it seem like almost nothing rather than being honest. I appreciate that I was given time to make me own choice of whether to talk about childhood experiences, and when and how. I understand the situations I was in better because of that time, as well as how we talked in session."*

> *"Quite relieved, it is not something i would want to talk about unless I had decided to bring it. I also do not feel my childhood adversity is as "bad" as others, so I would feel like I was taking up unnecessary space and would likely deny having experienced it to someone I did not have a relationship with or trust."*

3.2.15. Category 2: Negative Experience

13 participants reported that they had a negative experience when they were not asked about CA by MHPs, due to feeling unable to disclose by themselves, and feeling let down, or disappointed, that they had not been asked.

3.2.15.1. Unable to Disclose by Themselves: 3 participants expressed that they did not feel able to disclose CA by themselves or understand their CA without being directly asked by MHPs.

“I didn't really know how to bring up things myself as I wasn't confident enough.”

“I think it would have been easier to open up and probably earlier on, had I been asked direct questions. Being prompted would have helped me to find the words. It would have helped me understand that there were big reasons why I was struggling in the ways that I was. It was normal. I wasn’t just crazy out of nowhere.”

“I could never start the conversation myself.”

3.2.15.2. Invalidation and Disappointment: 10 participants reported feeling let down and invalidated when they were not directly asked about CA.

“Defeated. If a health professional was not interested, who could really help?”

“A bit disappointed that it didn’t come up. Maybe I would have liked to speak about it if it was brought up.”

“I felt very let down and almost as if they did not care as I know from growing up my childhood has impacted my adulthood and therefore, should be discussed and worked through with a mental health professional instead of them just assuming that the “generation I am” is the reason for mental health illnesses.”

“I felt let down and that nobody cared about me (which was true of my life in general, too). I also felt angry that this might be happening to other children and I am now dealing with the consequences of my childhood and hope others get support earlier on.”

3.2.16. Category 3: Mixed/Neutral Experience

Eight participants reported either a mixed or neutral experience when they were not asked about CA by MHPs.

3.2.16.1. *Neutrality:* four participants reported not having an overarching opinion or feeling about not being asked.

"Indifferent - I had never had any therapy before so I didn't know what to expect."

"Neutral - it's something that people need to disclose in their own time without pressure."

"I probably told them before they had the chance to ask so it didn't bother me."

3.2.16.2. *Initial Response Shifting Over Time:* four participants noted that they initially felt neutral about not being asked directly about CA, but then experienced positive or negative emotions about not being asked in hindsight.

"Nothing at the time because I did have other stuff to talk about it's only now I realise how much I'm still struggling with not working through that."

"At the time I didn't mind but now it would have been helpful to process."

"At the time I did not put much thought into it. I was new to mental health services and was quite reluctant to work with services. It is only as I have got older and more mature that I have realised that my childhood adversity probably was probably a major factor in me having a mental breakdown along with other life events and stressors."

4. DISCUSSION

4.1. Research Questions

The research questions were:

1. What do individuals report facilitated disclosure of CA to mental health professionals?
2. What are the barriers that individuals with experience of CA face when disclosing their experience to mental health professionals?
3. What were individuals' experiences of being asked, or not being asked, about their experiences of CA?

4.2. Summary of Main Findings

The current study was the first, to the researcher's knowledge, to explore, from the individual's perspective, the facilitators, and barriers of disclosing CA to MHPs, and the first to explore individuals' experiences of being asked, or not being asked about CA by MHPs. The current findings expand on previous research highlighting potential barriers and facilitators to disclosing traumatic experiences to MHPs, by offering a perspective that is grounded in the lived experience of individuals with CA.

4.2.1. Content Analyses

Participants identified several factors that facilitated disclosure of CA to MHPs, including the dynamics between the client and MHP (attunement, trauma competence, and therapeutic relationship), client's motivation to disclose (mental health decline, and to improve mental health), and the environment of the disclosure (feeling safe, having time to disclose).

Participants also identified several barriers to disclosing CA to MHPs, including the influence of the MHP (their demeanour, lack of enquiry about CA, and negative responses), the clients' experiences (impeded ability to disclose, anxieties surrounding disclosure, emotional barriers, and the clients' perceived significance of their CA), and the session environment (the treatment format and confidentiality).

Just over half (57.3%) had been asked about CA. Participants' experiences of being asked about CA included a range of emotions (positive, negative, and mixed). Their expectations about being asked (either expecting or not expecting to be asked) influenced how they experienced questions about CA.

42.6 of participants were not asked about CA. Participants experiences of not being asked about CA were positive (preferring to disclose by themselves), negative (difficulties disclosing by themselves, experiences of invalidation and disappointment), and mixed/neutral (experiencing neutrality, or their initial responses shifting over time).

4.3. What do individuals believe facilitated disclosure of childhood adversity to mental health professionals?

4.3.1. Facilitators to Disclosure

The study identified some important potential facilitators to disclosing CA to MHPs, highlighting interactions between the MHP and client dynamic, the client's own motivation for disclosing CA to MHPs, and the environment in which the disclosure may take place.

4.3.2. MHP and Client Dynamics

The most referred to facilitator to disclosure was the dynamics between the client and the MHPs. 26 participants expressed that positive verbal and non-verbal communication with the MHP aided disclosure. Participants stated that MHPs who listened, understood, validated, and were non-judgemental towards the client, enabled disclosure. These findings contribute to an established research base showing that the quality of the therapeutic relationship is a strong predictor of general therapeutic outcomes (Baier et al., 2020; Elliott et al., 2018; Ardito and Rabellino, 2011). These findings also support previous research identified in the earlier systematic review. Denov (2003) highlighted that participants experienced positive disclosure experiences when MHPs were supportive and understanding towards clients, and when they took the disclosure seriously. Similarly, the findings of Content Analysis 1 are consistent with findings by O'Brien et al (2017), who found that participants felt positive about disclosing to MHPs who listened, did not judge, and did not question participants about their experiences.

28 participants mentioned the trauma competence of MHPs (being trauma-informed, having specialist training in trauma, an ability to ask questions about CA, and not shying away from discussing trauma) as an important facilitator of disclosure. These findings contribute to the minimal existing research pertaining to facilitators of disclosure and support findings that trauma-related training results in increases in detection of trauma histories, and the frequency with which MHPs enquire about trauma histories (Coyle et al., 2019). Similarly, the results are consistent with findings that training specific to enquiring about trauma subsequently increases MHP knowledge, attitudes towards, and confidence in trauma enquiry (Lotzin et al., 2018; Pearce et al., 2019). The findings also support research suggesting that providing an opportunity to disclose by directly asking about negative experiences can facilitate earlier disclosure (McElvaney et al., 2013; Read et al., 2017).

10 participants stressed the importance of having a trusting and established therapeutic relationship with the MHP when disclosing CA. These results support Alaggia et al's (2017) review that highlighted relational processes, and having opportunities to disclose, such as within an established therapeutic relationship, as an influencing factor in disclosure.

4.3.3. Client Motivation

The finding that a client's own motivation may facilitate disclosure of CA also contributes to the limited research base concerning facilitators to disclosing CA. 21 participants reported that their motivation to disclose (struggling with mental health, seeking treatment to explore impact of CA with the aim of improving mental health) contributed to their disclosures. This finding somewhat supports the findings by Moore et al. (2015), who found that participants disclosed their CA to 'tell their story', and Smith (2020), who found that participants wished to disclose in hopes of distancing themselves from the impact of abuse. The results also support the findings of Alaggia (2005), that disclosure of CA often occurred following a mental health crisis, or hospital admission. Similarly, the findings confirm the notion that individuals may disclose traumatic experiences to allow for emotional processing of the trauma (Foa and Kozak, 1986).

4.3.4. Environment

33 participants shared that a safe and confidential environment contributed to their ability to disclose CA to MHPs, in addition to feeling safe whilst engaging with mental health support. These findings appear to be novel and are not addressed by any of the research identified within the systematic review. However, the findings meet the research recommendations of Alaggia et al's (2017) review of disclosure, which concluded that further research is required to understand and explore the influence of environment and context on disclosure. The findings that a safe and confidential environment may facilitate disclosure also holds important implications for training MHPs in trauma-informed care (see implications section).

4.4. What are the barriers that individuals with experience of childhood adversity face when disclosing their experience to mental health professionals?

4.4.1. Barriers to Disclosure

The current research highlighted several potential barriers to disclosing CA to MHPs, highlighting the role of the MHP, the client's own previous experiences of disclosing CA, and the environment in which the disclosure may take place.

4.4.2. Influence of MHP

The most referred to barrier to disclosure was the influence of the MHP (the MHP's demeanour, lack of enquiry about CA by MHP, and MHP's negative responses). 20 participants shared that MHPs who appeared to be detached, not understanding, pitiful, and dismissive, acted as a barrier to disclosing. Similarly, seven participants found it difficult to disclose when MHPs did not ask them direct questions about their experiences of CA. 33 participants also experienced negative responses by MHPs, such as lack of belief of CA, forgetting that participants had disclosed, and making inappropriate comments during disclosure. These findings are consistent with previous research exploring barriers to disclosure of abuse, such as Denov (2003), who explored the disclosure process and found that MHPs responded negatively to disclosures (showing shock, disbelief, discomfort, and minimisation of disclosed abuse), and Moore et al (2015), whose participants noted a lack of understanding regarding abuse extent and severity in helping professionals. The findings also support O'Brien et al. (2017) who found that professionals minimised the impact of childhood sexual abuse, and that many participants were not directly asked about abuse, Smith (2020), who reported discomfort by professionals and guiding the conversation away from disclosure and Read et al. (2007), who found that professionals may experience a range of barriers to enquiring about childhood abuse, such as beliefs that there were more immediate needs and concerns, and a lack of training in how to ask and respond to disclosures.

4.4.3. Client Experience

16 participants emphasised an impeded ability to disclose, either through not having the words to disclose, or due to the experience of physical and experiential difficulties with processing memories of CA. 14 participants also expressed fears and anxieties surrounding disclosure, and the potential impact of disclosing. 14 participants also highlighted a range of emotional barriers, such as guilt, shame, and embarrassment, and concerns about their experiences of CA not being significant enough to mention. These findings appear to be the most supported by previous research highlighting fears and anxieties surrounding disclosure (Alaggia, 2005; Collin-Vezina et al., 2015; Moore et al., 2015; Smith, 2020; Sorsoli et al., 2008). The findings are also consistent with research exploring factors impacting an individual's ability to disclose CA, for example, difficulties recalling due to the fragmented nature of traumatic memories (Herman, 1992), and fears of not being believed, experiences of shame, social taboo, (O'Leary and Barber, 2008; McElvaney et al., 2020; Ullman, 2007), and worries concerning the impact and consequences of disclosure (London et al., 2008). The findings that participants felt concern about their experiences not being significant enough to disclose appears to be a new finding, and highlights the importance of MHPs asking about different types of CA.

4.4.4. Session Environment

The current research found that 53 participants experienced environmental barriers to disclosure, such as the type and length of treatment, environmental barriers to disclosure (e.g., format of treatment being online, telephone, or face-to-face), and feeling unsafe to disclose, with fears of breaches to confidentiality. The data also highlighted that participant's perceived ability to disclose CA was impeded by the modality of treatment that they were offered (e.g., CBT). These findings link to earlier findings within the current research regarding the importance of an established therapeutic relationship and having the time to develop trust and a feeling of safety. The findings suggest that for time-limited treatment modalities, this may be more difficult for both clients and MHPs to experience. These findings are partially supported by previous research, such as O'Brien et al., (2017), who found that participants had difficulty accessing specialist childhood abuse services, Sorsoli et al., (2008) who highlighted lack of safety as a barrier to disclosure. There does not appear to be much existing research regarding the type, length, and format of treatment as a potential barrier to disclosure.

4.5. What were individuals' experiences of being asked, or not being asked, about their experiences of childhood adversity?

4.5.1. Enquiry rates

47 (57.3%) participants had been asked about CA, and 35 (42.6%) participants were not asked. It is difficult to compare these findings to existing research as it primarily focuses on enquiry rates regarding childhood abuse and/or neglect, rather than enquiry surrounding both conventional and expanded ACEs. Existing research suggests that enquiry of childhood abuse is low, and enquiry of neglect is even lower (Read et al., 2017). Nonetheless, it appears that despite more participants being asked by MHPs about CA, many individuals were not asked.

The current research also found that the average age of participants who were asked about CA was lower than those who were not asked. Although the difference was not quite statistically significant (using a two-sided t-test), the difference is consistent with previous findings that older people are less likely to be asked about experiences of abuse (Cavanagh et al., 2004; Read et al., 2017). Had a one-sided t-test been used, to test the specific hypothesis that older people are less likely to be asked, the difference would have been significant: *t* (80) = -1.71, *p* = .046.

4.5.2. Likert scale responses

For those who had been asked about CA, the majority felt that MHPs asked in a sensitive manner, and listened to, and acknowledged what participants were sharing. Similarly, most participants felt that they were satisfied with how the service responded to their disclosures, and that they received the support that they needed. Despite the generally positive response, some participants reported feeling unsatisfied, and that they did not receive the support that they needed. These findings suggest that there is a disparity in the experiences of participants who disclosed, highlighting that the level of care provided, and the responses of MHPs and services to disclosures of CA is variable.

4.5.3. Being asked

The findings of Content Analysis 3 explored experiences of being asked about CA by a MHP, and highlighted a range of experiences and expectations of clients when they were directly asked about CA by MHPs.

4.5.3.1. *Emotions Experienced:* A range of emotions were experienced by participants when directly asked about CA by professionals. The most common emotional response was positive, with 15 participants expressing feeling validated and relieved that they had been asked. Six participants reported negative emotions, feeling uncomfortable and nervous when they were asked. Nine participants experienced both positive and negative emotions, such as embarrassment talking about CA, but relief that they were asked. The findings of this content analysis contribute to a mostly unexplored area of research, regarding the process of disclosure and emotional responses to being directly asked questions about CA. Importantly, these findings contribute to research exploring MHP’s beliefs surrounding enquiry about abuse histories and contradicts reported beliefs that some MHPs believe that asking about CA may be detrimental to the client's wellbeing (Read et al., 2017).

4.5.3.2. *Expectations of being asked:* Eight participants reported that their experience and emotions surrounding being asked about CA by MHPs may have been influenced by their expectations of being asked. For those who expected to be asked (five participants), a lower level of emotional response was elicited. Those who had not expected to be asked (three participants) reported feeling shock and confusion regarding enquiry, but also reported that being asked contributed to increased realisation and understanding that their CA may have impacted their mental wellbeing. These findings appear to be related to the findings reported within the second content analysis (barriers to disclosure), in which participants did not know if their CA was significant enough to disclose. It appears that an understanding of CA and the potential impact on mental wellbeing may be an influential factor in choosing to disclose.

4.5.3.3. *Not being asked:* When participants were asked to share their experiences about not being asked about CA by a MHP, the overriding experience of participants was negative. 10 participants felt let down, invalidated, and disappointed that they had not been asked about their experiences, and expressed that, had a MHP asked directly about their experiences, they would have liked to have disclosed. This is an important novel finding that again highlights the importance of direct and routine enquiry about CA and supports research findings that individuals are unlikely to disclose experiences of CA spontaneously (Read and Fraser, 1998). Three participants, however, felt positive that they had not been asked, as they would have preferred to share their experiences by themselves. This finding also appears to be new; as previous research has focused predominantly on MHPs beliefs that clients did not wish to disclose (Kennedy et al., 2021), rather than on the client's own beliefs. Eight participants shared that they either felt neutral about not being asked, or that despite an initial neutrality, they felt that with hindsight, being asked may have been helpful to encourage processing of difficult experiences.

4.5.3.4. *Positive Experience:* Three participants shared that they felt positive regarding not being asked about CA, highlighting a preference to disclose on their own terms rather than being directly asked. These findings suggest that the process of disclosure is complex and may vary based on an individual's preferences, relationship with the MHP, and beliefs surrounding their CA, as suggested by Alaggia et al. (2017), who highlighted the influence of both internal and external factors on disclosure.

4.5.3.5. *Negative Experience:* The majority of participants who had not been asked about CA felt that not being asked impacted them negatively. 10 participants shared that they felt invalidated, disappointed, let down, and angry that a MHP had not asked them. Participants highlighted that this impacted them internally (feeling that nobody cared about them, that no one could help them), also highlighting potential external consequences of not being asked (that CA may be happening to other children and that they were not receiving earlier support if they weren't being asked about it). To the researcher's knowledge, no prior research has explored the emotional impact of not being asked about CA.

4.5.3.6. *Mixed/Neutral Experience:* Participants who had not been asked about CA by MHPs also reported feeling neutral towards not being asked, with some reflecting that the neutrality shifted over time towards a more negative experience. These results suggest that the emotions that are experienced when being asked/not being asked about CA are not rigid and may shift with hindsight and a greater understanding of the impact of CA on mental wellbeing, again highlighting the complexity of the process of disclosure and the elements that may impact an individual's desire, and intention to disclose.

4.6. Implications

4.6.1. Increasing Facilitators to disclosure of CA

Firstly, the study identified several facilitating factors that may increase clients' ability and motivation to disclose CA, from the client's perspective. Identification of facilitators to disclosure, such as positive dynamics between the client and MHP, trauma competence of the MHP and the establishment of a trusting therapeutic relationship, can inform training for MHPs regarding enquiry of CA and responses to disclosures.

The finding that clients can be motivated to disclose their CA for a variety of reasons highlights several settings and contexts in which disclosure of CA is more likely to happen (e.g., during hospital admissions, when seeking support specifically for the impact of CA), suggesting that routine enquiry within a range of mental health settings is crucial, to increase opportunities for clients to disclose their experiences and access appropriate support . Similarly, the finding that a safe and confidential environment can facilitate clients to disclose CA highlights the importance of offering clients a space in which they can feel safe, whilst upholding confidentiality practices within services, ensuring that clients are fully informed about confidentiality.

4.6.2. Decreasing barriers to disclosure of CA

The identification of barriers to disclosure of CA can also contribute to the development of existing trauma-informed training and practice regarding responding to disclosures, acknowledgement and support with managing clients' anxieties surrounding disclosure, and the development of therapeutic environments that enable disclosure (Read et al., 2007; DuSoulier, 2021). It is important to note that participants disclosed several inappropriate and potentially retraumatising responses of MHPs during the disclosure process, highlighting an increased need for training in trauma-informed care. Similarly, 35 participants noted that they had not been directly asked by MHPs about CA, meaning that clients were not given an opportunity to disclose, and felt that, had they been asked, they would have disclosed sooner which may have resulted in earlier access to the appropriate support required. This finding reinforces the findings regarding spontaneous disclosure (Read and Fraser, 1998) and supports the notion that routine enquiry is crucial in encouraging disclosures of CA, and that providing clients with an opportunity to disclose may decrease barriers.

Exploration of the client's internal experiences when considering disclosure of CA highlighted that many felt anxiety and shame, in addition to feelings that their CA was not significant enough to disclose. This suggests that transparent exploration of the feelings and experiences arising during the disclosure process by the MHP may contribute to increased confidence and perceived ability of the client to discuss their experiences.

The findings suggest that the therapeutic environment is a crucial factor that may facilitate, or act as a barrier to, disclosure. Many participants felt that they did not have enough time to build trust with the MHP, that they did not feel safe, and that restrictions on the number of sessions offered acted as a barrier to disclosure. Some participants also highlighted several confidentiality breaches made by MHPs. This highlights the importance of offering a confidential space for clients to disclose. Similarly, the treatment format was sometimes found to act as a barrier, for example, if the opportunity to disclose occurred via virtual means, or over the telephone. In addition, the findings suggest that certain treatment modalities (such as CBT) may inhibit both clients' and MHPs ability to adequately explore the impact of CA on mental wellbeing. These findings highlight the importance of early detection of CA, so that clients can be offered the appropriate treatment type and format.

4.6.3. Asking about CA

The current research highlights the importance of MHPs directly asking about CA. 35 participants were not directly asked by MHPs and 10 participants expressed disappointment that they were not asked. Similarly, 15 participants who were asked mentioned feeling relieved and validated following enquiry. The findings that participants did not have the words to disclose/did not know if their CA was significant enough to disclose, in addition to previous findings that rates of enquiry (Read et al., 2017) and spontaneous disclosure (Read and Fraser, 1998) are low, suggest that routine enquiry is important in providing clients with increased opportunities to disclose. Similarly, the insights provided within the current research exploring clients' perspectives surrounding enquiry of CA offer important evidence that further informs previous research regarding perceived barriers to disclosure by MHPs.

There appears to be differences in clients' preferences regarding when MHPs enquire about CA, and as such, it is difficult to provide a definitive answer regarding the most appropriate time for MHPs to enquire about CA. Whilst some participants highlighted a preference to be asked by MHPs, and that enquiry of CA built trust with their MHP, other participants expressed a preference for rapport to be built before asking. Nonetheless, it is still crucial for MHPs to practice routine enquiry with each client. It is possible that increased access to trauma-informed training may equip MHPs with an enhanced ability to exercise clinical judgement regarding the appropriate time for enquiry. Similarly, the use of questionnaires exploring preferences surrounding enquiry of CA and experiences of CA, could be a useful tool to indicate client preferences.

The current findings explored barriers to disclosure from the client's perspective, contrary to existing research that predominantly explored barriers to enquiry of CA that MHPs experience. A comparison of the existing research to the findings of the current research, and the implications of the findings are provided below (See Table 13). A summary of key studies was informed by a review conducted by DuSoulier (2022). The summary draws on findings from nine studies (Day et al., 2003; Kennedy et al., 2021; Lab et al., 2000; Mansfield et al., 2017; McLindon & Harms, 2011; Mitchell et al., 1996; Toner et al., 2013; Walsh et al., 2021; and Young et al., 2001), across the UK, Ireland, the US, Australia, and New Zealand, with a range of MHPs.

Table 10. Comparison between Barriers Identified in Previous Research and Current Findings

Barrier Identified	Current Findings and Interpretation
Therapeutic relationship: Beliefs that enquiry is appropriate once a therapeutic relationship is established, reliance upon the therapeutic relationship and intuition to introduce questions about abuse, fear that questions may damage the relationship due to intrusion.	10 participants mentioned the establishment of a trusting therapeutic relationship as a facilitator to disclosure. One participant expressed a desire for trust to be built before being asked about CA. Lack of rapport with the MHP was also cited as a barrier to disclosure. This suggests that the establishment of a therapeutic relationship is helpful for both clients and MHPs during the disclosure process, but that the extent to which the relationship is developed before asking or disclosure feels appropriate may differ depending on clients' and MHPs' preferences surrounding being asked about CA.
Remit of the work: Beliefs that childhood sexual abuse is not relevant, or secondary to particular psychological presentations, there being more immediate concerns and priorities.	Six participants expressed worries that their CA was not significant enough to disclose. 10 participants also felt disappointed that their CA was not addressed, as the treatment offered/MHP did not focus on CA. Despite the existing research focusing exclusively on childhood sexual abuse, the established link between sexual abuse and other forms of CA, and many psychological and physical health conditions suggests that the consideration of the impact of CA on psychological presentations is crucial in understanding the client's presentation and in providing appropriate support.
Fear of harm: Beliefs that enquiry could result in retraumatisation or a deterioration in psychological wellbeing.	Retraumatisation or deterioration in psychological wellbeing because of CA enquiry was not identified by the current research. Whilst six participants expressed discomfort about being asked, 15 participants found the experience of enquiry positive.

	Similarly, lack of enquiry of CA resulted in negative experiences for 16 participants, suggesting that experiences of enquiry may be variable. Nonetheless, the current study found no evidence of detrimental impact to psychological wellbeing resulting from enquiry of CA.
Waiting for client to disclose: Beliefs that clients should be able to disclose on their own terms, by their own choice, and take the lead in disclosure.	Three participants specified a preference to disclose on their own terms, as direct enquiry may have resulted in defences and non-disclosure. However, five participants shared that they expected to be asked, and three participants stated that they felt unable to disclose by themselves. Similarly, 10 participants felt disappointed and invalidated when they were not asked about their experiences. The findings indicate that clients may have differing preferences regarding enquiry of CA, and that exploration of preferences may reduce barriers to, and facilitate disclosure.
Perceived lack of skills to provide required support/lack of training/discomfort discussing abuse: Fear of responding incorrectly, experiencing discomfort, lacking confidence in enquiry and responding, feeling underqualified.	33 participants shared past experiences of MHPs who appeared uncomfortable and dismissive when discussing CA, which acted as a barrier to disclosure, whereas 28 participants highlighted the trauma competence of the MHP as a facilitator to disclosure. This suggests that training in routine enquiry and management of disclosure may reduce barriers to disclosing.
Vicarious trauma: Some MHPs reported that disclosures negatively impacted their wellbeing,	There were no findings in the current study relating to vicarious trauma. However, 14 participants expressed anxieties about disclosing, one of which shared that they were worried their disclosure would scare the

potentially resulting in lower enquiry rates.	MHP. These findings indicate that further research on disclosure and vicarious trauma is warranted.
Lack of supervision: Lack of access to adequate supervision and feeling a lack of support in working with clients with experience of abuse.	These findings were not found within the current research, which is expected as supervision and support surrounding disclosure is specific to MHPs.
False memories: Fear of producing false memories through enquiry, e.g., if a client is experiencing psychosis.	There was no evidence of false memories being produced through enquiry in the current study. However, of the 96 participants, only 47 were asked about CA, and the survey did not explore the production of false memories, so the findings lack generalisability and warrant further research.
Biological aetiological beliefs: Holding biological aetiological beliefs surrounding mental health difficulties, resulting in lower enquiry about abuse.	Lack of belief of the impact of CA, was seen as a barrier to disclosure. Similarly, participants shared experiences of MHPs appearing disinterested about CA, and negative past experiences of minimisation of abuse. These findings suggest that it is important for MHPs to develop an understanding of the psychological impact of CA, which may encourage increased routine enquiry.
Lack of availability of appropriate treatment: Lack of appropriate treatment for those with abuse histories, lack of clarity surrounding necessary protocols following disclosure of abuse.	35 participants found the treatment format (type of treatment, length of treatment, environment) to be a barrier to disclosure), these findings, combined with previous findings regarding MHPs also finding the lack of availability of appropriate treatment a barrier to enquiry, indicates an increased need for increased access to specific, trauma-informed services.

4.7. Research Recommendations

Overall, it appears that research exploring the facilitators and barriers to disclosing CA to MHPs, from the individuals' perspective, is limited. Research regarding clients' experiences of being asked/not being asked about CA is also scarce. The few existing studies have focused on barriers to disclosing childhood abuse and neglect, thus overlooking barriers (and facilitators) to disclosing other forms of CA. Research has also tended to focus on barriers to disclosure from the perspective of the MHP, rather than the individual who is disclosing. The current study has produced new findings that warrant further exploration. As such, the researcher proposes recommendations for future research:

4.7.1. Research on Expanded ACEs

Research exploring the impact of expanded ACEs on mental wellbeing is scarce (Cronholm et al., 2015). Future research should attempt to explore prevalence rates of expanded ACEs, and potential correlations between experiences of conventional ACEs and expanded ACEs. Similarly, research regarding the development of screening measures that explore expanded ACEs in addition to conventional ACEs is warranted. Gaining more insight into the prevalence of expanded ACEs, and their impact on mental health, may further encourage routine enquiry in services and may support MHPs with identifying experiences of expanded ACEs.

4.7.2. Research Exploring Clients' Experiences of Being Asked/Not Being Asked About CA

Research that builds on the findings of the current study regarding clients' experiences of being asked/not being asked about experiences of CA could explore further, from the clients' perspective, the appropriate time to ask clients, how to ask about experiences, and how to facilitate transparent conversations regarding enquiry and disclosure of traumatic experiences. A similar design to the current study, perhaps using semi-structured interviews, may allow for richer data regarding experiences of enquiry of CA. As mentioned above, research may also seek to explore the impact of enquiry of CA on MHPs (e.g., vicarious trauma, compassion fatigue, the impact of access to supervision and staff support), and the impact of enquiry on clients (potential of enquiry resulting in retraumatisation). This research may contribute to the development of trauma-informed care and training, subsequently increasing MHPs confidence and motivation to enquire about CA.

4.7.3. Research Exploring Facilitators of Disclosure of CA

Further research exploring facilitators of disclosure of CA is warranted based on the findings of the current research. The disparities in experience of participants suggests that the disclosure process is complex and can be influenced by individual, interpersonal, sociocultural, and environmental factors (Alaggia et al., 2017). A greater understanding of existing facilitators of disclosure can inform training and service protocols, enabling services to anticipate and reduce potential barriers, and implement changes to protocols that facilitate disclosure (e.g., routine enquiry, establishment of the therapeutic relationship, safe and confidential therapeutic environments, and awareness of the importance of attunement with the client).

4.7.4. Research Exploring Male Experiences of Disclosure

The findings of the current research were based upon a predominantly female sample, and previous research has identified difficulties with recruiting male participants (Sorsoli et al., 2008). Given that previous research has identified distinct differences of barriers to disclosure experienced by males and females (Alaggia, 2005), including low rates of routine enquiry about sexual abuse in male patients, and professionals' feeling insufficiently trained in asking males about sexual abuse (Lab et al., 2000), future research is needed to explore enquiry and disclosure of CA relating to males in more depth. Future research may also seek to explore the difficulties surrounding recruiting male participants.

4.8. Clinical Recommendations

The provision of training that is informed by disclosure research may be helpful in encouraging routine enquiry about CA, knowing how and when to ask about CA, and increased knowledge about the facilitators and barriers of disclosing CA and potential differences in disclosure experiences. As such, clinical and service-level recommendations are proposed:

4.8.1. Training and support for MHPs

As mentioned above, training for MHPs in trauma-informed care and the process of disclosure is essential to ensure an increase in disclosure facilitators, a decrease in disclosure barriers, and increased understanding of the impact of CA on mental health. As prior research confirms, MHPs confidence and motivation in asking about CA increases with appropriate training (Lotzin et al., 2018; Pearce et al., 2019). Similarly, adequate support for MHPs who are hearing disclosures of traumatic experiences is crucial to ensure that they feel adequately supported and equipped to respond with compassion and empathy. This may be achieved through regular clinical supervision and reflective practice (Dehlin and Lundh, 2018).

4.8.2. Asking about conventional and expanded ACEs

Training may also provide an opportunity to reiterate the importance of asking about a range of ACEs that may not be covered in conventional service screening. Encouragement of routine enquiry of CA is crucial, given that individuals are unlikely to disclose spontaneously (Read and Fraser, 1998) and may delay the individual accessing the appropriate support. As prior research has highlighted MHPs reservations of asking about traumatic experiences, it is important that training highlights the importance of developing a trusting therapeutic relationship, offering clients an opportunity to disclose should they wish to do so, and developing a therapeutic space in which clients feel safe enough to potentially disclose, as facilitators to disclosure. Similarly, it is important to note that a trusting therapeutic relationship may further develop with transparency and open enquiry about CA, but that this may not be experienced in the same way by every individual. As such, offering the choice and opportunity to clients to disclose may provide the client with autonomy in making decisions surrounding disclosure. Subsequently, it may be helpful to encourage transparent exploration of clients' beliefs surrounding asking about CA, as the research suggests that participants may experience being asked/not being asked in different ways. At a service-level, consideration of alternative screening measures, such as the expanded ACE questionnaire (Cronholm et al., 2015), may enable earlier detection of CA.

4.8.3. Facilitators and barriers experienced by different populations

It is important to consider the disparities between enquiry of CA for different ages and genders. Providing training and reflective spaces exploring common societal discourses about the types of CA that individuals of a particular gender or age may have experienced, and assumptions regarding perceived tolerance of discussing traumatic experiences may encourage enquiry about CA for all individuals presenting to services.

4.9. Reflexivity

4.9.1. Researcher Interest

The research topic was chosen due to my own interests in complex trauma, disclosure, and specialist trauma services. Prior to clinical psychology doctoral training, I had worked in a primary care adult mental health setting triaging self-referrals. I was struck by the number of clients who had self-referred for support due to childhood trauma and found myself subsequently being the first clinician that many clients had shared their experiences of CA with. I also witnessed the difficulty that clients faced when attempting to seek help for the impact of childhood trauma, as specialist trauma care was only offered for those who met criteria for PTSD, meaning that, to access appropriate support, clients would need to disclose potentially distressing details about their experiences. I was acutely aware of the nature in which I was asking clients about their experiences, and my responses when they were disclosed, or not disclosed, which raised further questions surrounding trauma-informed practice and enquiry of CA, in addition to what may facilitate, or act as a barrier to, disclosure.

My first clinical psychology doctorate placement was in a secondary care service, within the PTSD stream, in a diverse borough in outer London. In this placement I noticed a large number of clients who had experienced adversities in childhood that were not included in conventional trauma questionnaires utilised by the service, despite the evident impact of adversities such as childhood poverty, discrimination, and bullying. I saw that many of these impactful events and circumstances had been missed by clinicians in initial assessments and previous treatment, and that the opportunity to reflect upon and process the impact of common childhood adversities may not have been given to clients, as they had not been asked about them.

On my fifth clinical psychology placement, within a service that offers longer term, specialist treatment for complex trauma, I had the opportunity to reflect upon the importance of developing a trusting therapeutic relationship with clients who had extensive experience of CA, and that to continue specialising in complex trauma, the critical reflection upon trauma-informed care, enquiry of all forms of CA, and experiences of disclosure, would be crucial and integral to my development as a clinical psychologist. With further research, I found that there is very little known about the disclosure process of many forms of CA, and the subsequent barriers and facilitators of disclosing to MHPs.

4.9.2. Impact on Research

It is likely that my own experiences of CA and disclosure to MHPs, in addition to my beliefs that CAs can impact mental health and values as a clinician (the importance of practicing trauma-informed care, providing opportunities within the context of the therapeutic relationship to disclose CA), impacted and shaped the way that the research was designed and analysed. Having experienced disclosure of expanded ACEs, and a positive experience of being asked about my experiences in clinical assessments, I was curious about other people's experiences, and whether they were similar or different from my own. My personal interest, in line with my experiences as a service-user and clinician, ultimately informed the research methodology, questions asked, and the analysis of results. I felt that a qualitative methodology would allow for richer data, and an opportunity for participants to share their experiences on their own terms. Similarly, offering the choice to provide anonymous information about experiences was informed by my experiences as a clinician, having perceived the difficulties that clients often face when providing feedback on their treatment to clinicians that they have an established relationship with.

Use of the Expanded ACE questionnaire was informed by my clinical experience and belief that many ACEs are missed in conventional screening questionnaires, and that cultural and social trauma can have a detrimental impact on mental health. The analysis of data, and organisation of each content analysis (and the subsequent categories into which experiences were allocated to), was inevitably influenced by prior research on disclosure, and the distinct lack of research pertaining to facilitators. My own assumptions that experiences were either barriers or facilitators to disclosing CA may have differed from that of the participant (e.g., being directly asked about CA), and this became evident in Content Analysis 4, with some participants expressing that they preferred to disclose themselves rather than be asked. An example of the subjectivity of the content analysis process is the choice to include two subcategories in Content Analysis 1, Category 2. The subcategories 'Mental Health Decline' and 'Motivated Disclosure' could be interpreted as similar, and another researcher may have categorised them together. I chose not to, as I felt that having two subcategories allowed separation of the (subjectively) negative experience of 'Mental Health Decline', versus 'Motivated Disclosure', which appeared more explorative for participants.

4.9.3. Reflections During the Research Process

Through ongoing critical reflection during the research process, I considered the potential impact of asking participants to disclose their CA through questionnaires and direct questioning about their experiences, and that it may be distressing to recall negative experiences of disclosure, despite the steps taken to reduce distress. Similarly, my own role as a clinical psychologist in training may have influenced who chose to take part in the research and may potentially have impacted the responses provided despite anonymity. Participants may have understated their experiences with other clinical psychologists, due to my sharing of the title and role. It is possible that my values related to trauma-informed care may have influenced the questions asked in the survey, such as those related specifically to enquiry of CA, and likert-scale response questions. My own assumptions that there are existing barriers and facilitators to disclosing CA, and that clients may have an emotional response to being asked, or not being asked, about CA, may have influenced my interpretation of the data. It is possible that responses that were not strongly positive or negative were categorised based on my own assumptions about the experience shared and how I may have responded to it had it been my own experience.

4.10. Limitations

4.10.1. Generalisability of findings

Firstly, the recruitment method of convenience sampling via trauma-specific groups and social media inevitably increased sampling bias. Members of trauma-specific groups may have had an increased willingness to share their experiences, and an increased understanding of the potential impact of CA on mental wellbeing. It is possible that this sampling method missed individuals with CA who may have had less of an understanding of what CA is, and the subsequent impact that it can have. Similarly, the study may have appealed to those with 'negative' experiences of disclosing CA (such as not being asked about CA) as the survey provided a space in which to share a range of experiences.

The population sample recruited for the current research predominantly consisted of white females, with high levels of education and in full- or part-time employment. As such, the findings may not be generalisable to the wider population. As expanded ACEs are experienced at the community level (Cronholm et al., 2015), it is possible that the level of adversity experienced by non-white, less-educated, socioeconomically deprived populations differs from that of the current sample. The barriers and facilitators identified may not be generalisable to other genders, due to the small number of male and non-binary participants (12 participants). In addition, the inclusion criteria of individuals aged between 18-40 meant that individuals outside of this range were unable to share their experiences. It is important that research exploring enquiry of CA encompasses a range of ages, due to the findings that older individuals are less likely to be asked about CA (Cavanagh et al., 2004, Read et al., 2009).

4.10.2. Methodological Issues

Despite the randomised coding by the research supervisor to explore what quantitative researchers call 'inter-rater reliability', content analysis as a methodology is subjective in nature, and relies upon subjective interpretation. Content analysis can also be reductive due to the large volume of text and the use of manual coding, meaning that some of the data was excluded for not appearing often enough, or not fitting into distinct categories. It is also possible that asking direct questions about CA, via an anonymous, online survey may have produced results that would have been different if the research had taken place face-to-face, for example, via interviews, especially as the results highlighted the role of inter- and intra-personal dynamics and relations in disclosing experiences.

4.10.3. Definition of CA

A definition of CA was provided in the research advertisement and in the PIS. The definition provided was my own interpretation of what CA is, based on previous research and my own understanding of CA, and is therefore subjective. Participants may have made different interpretations, or held different beliefs, regarding what CA is. As having CA was one of the inclusion criteria for the research, it is possible that individuals with CA, but with a different understanding of CA than what was specified by the research, were either excluded from the research or may have chosen not to take part in the research.

4.11. Dissemination

The findings from the current research will be disseminated through a range of means. Firstly, those who participated in the study and indicated an interest in the findings will be provided with a summary of the results and the completed thesis. The findings will also be presented to an NHS specialist psychotherapy service during an academic morning event. The researcher aims to publish the findings of the current research in peer-reviewed journals.

4.12. Conclusion

In conclusion, this is the only existing research to the researcher’s knowledge that explores, from the clients’ perspective, the facilitators, and barriers to disclosing CA to MHPs, and their experiences of being asked or not being asked by MHPs about CA.

The use of an anonymous survey enabled the collection of rich data that provides valuable insights into individuals with CA’s experiences of disclosure and enquiry of CA, and highlights several areas in which change can be enacted to decrease barriers to, and facilitate disclosure and routine enquiry of CA.

The identification of several facilitators to disclosure is optimistic and contributes to the limited existing research base regarding facilitators to disclosure. The identified facilitators may further inform MHP's trauma-informed practice and training, and service-level initiatives to promote routine enquiry and early identification of CA, with the hope that earlier access to mental health interventions will be enabled. The findings confirm that MHPs are instrumental in increasing the facilitators, and decreasing the barriers to disclosure of CA, and that it is possible to do so by accessing training, and increasing knowledge of facilitators and barriers.

Perhaps the most important finding is that the dynamic between the MHP and client can act as a facilitator to disclosure. These findings indicate the importance of increased access to trauma-informed training for MHPs, that encourages rapport building, the development of a trusting therapeutic relationship, and engaging with clients in a trauma-informed manner.

Of the barriers identified, the influence of the MHP was referred to most frequently, and suggests that further training regarding beliefs surrounding CA and the potential impact on psychological wellbeing, and support for professionals, perhaps in the form of supervision and reflective practice, is crucial to reduce barriers to routine enquiry of CA. Similarly, the findings support the notion that policy regarding routine enquiry by MHPs requires further implementation and governance by governing bodies.

Through the identification of facilitators and barriers to disclosure, recommendations have been made regarding MHP training, service-wide initiatives, and future research. The findings of the current research provide MHPs, mental health services, and researchers with an increased understanding of the inter- and intra-personal, sociocultural, and environmental factors that may facilitate and act as barriers to disclosure.

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6. APPENDICES

Appendix A: Summary Table of Studies Included in Systematic Review

Table 1: Summary Table of Studies Included in Systematic Review

Study and location	Participants and type of adversity	Aim of study	Methodology	Main themes/findings	Specific barriers/facilitators mentioned?	Limitations
1. Alaggia (2005). Disclosing the Trauma of Child Sex Abuse: A Gender Analysis. Canada	30 adult participants with experience of childhood sexual abuse. aged 18-65, two thirds female. Diverse socioeconomic status and ethnicity.	To explore dynamics that impede or promote disclosure of childhood sexual abuse - with a focus on gender.	Qualitative - Thematic analysis, semi-structured interviews.	Gender may influence disclosure. Disclosure is generally delayed by both males and females. Disclosure often precipitated by a 'breakdown', resulting in long term therapy.	Barriers: Abuse by a male to another male resulted in the victim developing concerns about sexual orientation. Experience of prevailing heterosexual/homophobic attitudes in society. Fears of being viewed as a victim. Fear of being labelled as an abuser following disclosure.	Limited generalisability. Did not explore facilitators of disclosure.

					Females feeling a responsibility to others, experiencing anticipation of being blamed/not believed by others. Facilitators: not identified.	
2. Collin-Vezina et al., (2015). A preliminary mapping of individual, relational, and social factors that impede disclosure of childhood sexual abuse. Canada	67 adult participants with experience of childhood sexual abuse, aged 19-69 who had recently accessed counselling services. Approximately two thirds female.	To provide a preliminary mapping of barriers to disclosure of childhood sexual abuse using an ecological systemic lens.	Qualitative - grounded theory, semi-structured interviews.	Findings suggest that disclosure is complex and influenced at the individual, familial, social, community and cultural levels (multi-level conceptualisation of disclosure). Identified three themes - barriers from within, barriers in relation to others, barriers in relation to social world.	Barriers: Barriers from within: internalised victim blaming, mechanisms to protect oneself, being too young to comprehend the situation. Barriers in relation to others: Family, violence/dysfunction, power dynamics, awareness of potential impact of disclosing, fragile social network.	Homogenous sample - lack of generalisability Did not explore facilitators to disclosure.

					Barriers in relation to social world: Labelling/stigma, sexuality taboo, lack of services available to help, culture/time in which abuse took place. Facilitators: Not identified.	
Denov (2003). To a safer place? Victims of sexual abuse by females and their disclosures to professionals. Canada	14 Canadian survivors of childhood sexual abuse by a female perpetrator, aged 23-59, recruited through professional referrals/counselling service poster.	To explore experiences of disclosure of sexual abuse by a female perpetrator to professionals, and to explore the impact of responses by professionals.	Qualitative, thematic analysis, semi-structured interviews.	The majority of disclosures took place within the context of a therapeutic relationship, as adults. The timing of disclosure was often relevant to cultural sensitivity/awareness towards childhood sexual abuse.	Barriers: Participants reported fears of disclosing their abuse due to the gender of the perpetrator. Fear of not being believed. The professional appeared uncomfortable and resistant. Professional’s tendency to minimise abuse by females.	Lack of generalisability.

					Professionals showing shock or disbelief. Facilitators: supportive and understanding stance by professionals following disclosure. Being treated as credible, professionals treating the disclosure seriously, and comfortably.	
Moore et al., (2015). On the road to resilience: The help-seeking experiences of Irish emigrant survivors of institutional abuse. UK	22 participants aged 53-69 self-reported survivors of institutional childhood abuse in Ireland (childhood sexual, physical, emotional abuse and neglect, poverty, child labour).	To illustrate the help-seeking experiences of those who have experienced institutional childhood abuse.	Qualitative, thematic analysis, semi-structured interviews.	Reliance on self-management techniques used in childhood to deal with difficulties impacted the approach to disclosing. Intentional action to disclose impeded by those in power.	Barriers: Self-management techniques would delay disclosure - prioritising the needs of others. Calls for help ignored or suppressed by religious or educational authorities Interpersonal beliefs - helping professionals and the general public did not understand horrific	Only two males within the sample. Small sample, less generalisability. No information on facilitators to disclosure.

					realities that were occurring. More awareness of sexual abuse, less so of verbal assaults, physical beating, personal and emotional neglect. Sense of loss of control and powerlessness. Interactions with professionals who hold power drew parallels to experiences with authorities in childhood. Educational disadvantage - difficulties in form filling resulting in disengagement. Facilitators: Not identified.	
O'Brien et al., (2007).	14 female survivors of childhood sexual,	To explore experiences of women	Qualitative, focus groups and interviews,	Participants found help later than sooner, many sought help due	Barriers: Professionals minimising impact of abuse.	Age of participants not given - only that

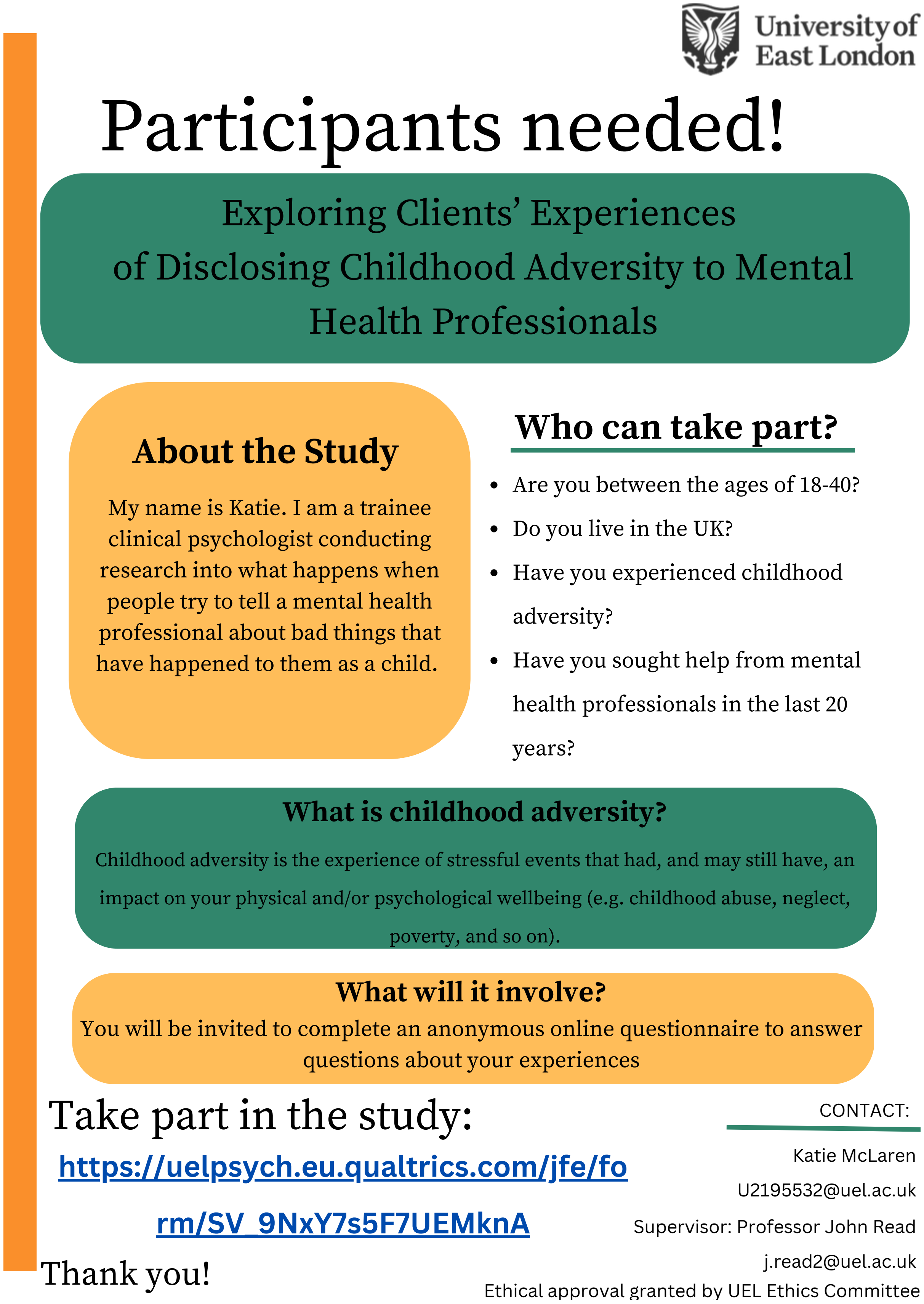
Finding a place for healing: Women survivors of childhood sexual abuse and their experience of accessing services. Australia	physical and emotional abuse.	survivors of childhood abuse in accessing and using services.	common issues were identified and grouped.	to being overwhelmed with strong childhood memories of abuse and assault. Described experiences of disclosure as often including minimising the effect of the abuse by professionals, such as psychiatrists. Sensitivity to rejection - indications of impatience or diffidence would result in disengagement.	Not being allowed access to therapy due to substance use. Long waiting lists and not being a priority. Difficulties telling story repeatedly and questioning of memories/validity as distressing. Poor understanding in the broader community of abuse in childhood e.g. related abuse to strangers rather than intra-familial abuse. Facilitators: No judgement, no questioning of the truth, not being shocked by disclosure. Feeling heard and understood. Access to long term counselling - the length of counselling seen to be	they were adult women. Small sample - not representative. Instances of other forms of CA not quantified.

					what made a difference in relation to establishing a trusting relationship. Being able to deal with practicalities of housing, education, employment, routine establishment before disclosure, to have stability.	
Smith (2020). Adult male survivors' disclosure of childhood sexual abuse: An interpretative phenomenological analysis. US	3 male survivors of childhood sexual abuse, aged, 48, 54, and 67.	To explore how male survivors of childhood sexual abuse understand their experiences of disclosure to a MHP.	Qualitative, Interpretative phenomenological analysis (IPA), semi-structured in person interviews.	Four themes identified: Alone and not alone - relation to experiences of disconnection and subsequent hopes for connection via disclosure. Throwing grenades - experiences of discomfort felt in others when disclosing.	Barriers: When attempting to disclose - MHPs tip-toed around uncomfortable topics, steering away from discussion of abuse. Stigma of CSA. The MHP arresting control of the disclosure away from the survivor - attention on the abuser without consideration of the survivor's opinions.	Homogenous participant group, limited transferability.

				Monsters in the deep - experiences of abuse becoming its own entity. That's not what I wanted - immediate responses of professionals guiding away from disclosure.	Experiencing discomfort from MHPs when disclosing. Facilitators: Connecting with those who share common experiences. Having relationships with other survivors encouraged help-seeking and disclosure to MHPs - and practicalities of finding help.	
Sorsoli et al., (2008). 'I keep that hush-hush': Male survivors of sexual abuse and the challenges of disclosure.	16 male survivors of childhood sexual abuse, aged 24-61 years.	Who did the participants disclose experiences to, what was their experience of the disclosure, what do they perceive to be the positive and	Qualitative, grounded theory, semi-structured interviews.	Experiences of disclosure considered on three levels: personal, relational, sociocultural.	Barriers: Personal: Cognitive awareness, intentional avoidance, difficulty approaching the topic, difficulty articulating, emotional readiness, safety and shame. Relational:	Lack of focus on facilitators, but does reflect upon this (e.g. participants mostly spoke about barriers).

US	negative aspects of experiences of disclosure?	Isolation, relational beliefs, disruptions to relationships, fear of specific negative repercussions. Sociocultural: Unacceptability. Facilitators: Not identified.

Appendix B: Research Advertisement



University of East London

Participants needed!

Exploring Clients' Experiences of Disclosing Childhood Adversity to Mental Health Professionals

About the Study

My name is Katie. I am a trainee clinical psychologist conducting research into what happens when people try to tell a mental health professional about bad things that have happened to them as a child.

Who can take part?

- Are you between the ages of 18-40?
- Do you live in the UK?
- Have you experienced childhood adversity?
- Have you sought help from mental health professionals in the last 20 years?

What is childhood adversity?

Childhood adversity is the experience of stressful events that had, and may still have, an impact on your physical and/or psychological wellbeing (e.g. childhood abuse, neglect, poverty, and so on).

What will it involve?

You will be invited to complete an anonymous online questionnaire to answer questions about your experiences

Take part in the study:

https://uelpsych.eu.qualtrics.com/jfe/form/SV_9NxY7s5F7UEMknA

Thank you!

CONTACT:

Katie McLaren
U2195532@uel.ac.uk
Supervisor: Professor John Read
j.read2@uel.ac.uk
Ethical approval granted by UEL Ethics Committee

Appendix C: Online Survey

Exploring Clients' Experiences of Disclosing Childhood Adversity to Mental Health Professionals

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Start of Block: Information sheet

PIS 1

Version: 1
Date: 24/01/2023

PARTICIPANT INFORMATION SHEET

Exploring Clients' Experiences of Disclosing Childhood Adversity to Mental Health Professionals

Contact person: Katie McLaren (Trainee Clinical Psychologist)
Email: u2195532@uel.ac.uk

You are being invited to participate in a research study. Before you decide whether to take part or not, please carefully read through the following information which outlines what your participation would involve. Feel free to talk with others about the study (e.g., friends, family, etc.) before making your decision. If anything is unclear or you have any questions, please do not hesitate to contact me on the above email.

Who am I?

My name is Katie McLaren. I am a postgraduate student in the School of Psychology at the University of East London (UEL) and am studying for a professional doctorate in clinical psychology. As part of my studies, I am conducting the research that you are being invited to participate in.

What is the purpose of the research?

I am conducting research into the experiences that people have when they attempt to tell a mental health professional about their experience of childhood adversity. Childhood adversity is the experience of stressful events that had, and may still have, an impact on your physical and/or psychological wellbeing (e.g. childhood abuse, neglect, poverty, and so on).

The aim of the study is to understand the barriers that people might face when telling mental health professionals about their experiences of childhood adversity, in addition to what people found helpful and/or unhelpful when sharing these experiences. I am also interested in the similarities and differences of the experience of telling (or not telling) mental health professionals about childhood adversity, based on what the childhood adversity was. I hope that the findings of the research can be used to improve mental health professionals' understanding of how they can help people to share their experiences of childhood adversity and subsequently access the psychological support that they may need.

Why have I been invited to take part?

To address the study aims, I am inviting people who have had experience of childhood adversity to take part in my research. If you are between the ages of 18 and 40, have experienced childhood adversity, and have sought support from mental health services in the past 20 years, you are eligible to take part in the study.

It is entirely up to you whether you take part or not, participation is voluntary.

What will I be asked to do if I agree to take part?

If you agree to take part, you will be asked to complete an anonymous, online survey, that will ask you several questions about your demographics, early childhood experiences and your experience of telling (or not telling) these experiences to mental health professionals. You will also have the opportunity to provide your email address if you are happy for us to contact you for an interview about your experiences.

There are approximately 50 questions to answer. We estimate that the study may take approximately 30 minutes to complete. Some of the questions will be short and quick to answer. Some questions (those asking you to describe your past experiences) may take slightly longer to answer.

Can I change my mind?

Yes, you can change your mind and withdraw without explanation, disadvantage or consequence, within three weeks of completing the survey. If you would like to withdraw from the survey whilst completing it, you can do so by closing the survey. If you withdraw, your data will not be used as part of the research.

Separately, you can also request to withdraw your data from being used even after you have taken part in the study, provided that this request is made within three weeks of the data being collected (after which point the data analysis will begin, and withdrawal will not be possible).

Are there any disadvantages to taking part?

It is possible that answering questions about difficult past experiences may result in some distressing feelings arising. Please do not continue to answer questions in the survey if they are causing you significant emotional distress.

The NHS provides a list of useful helplines if you find yourself negatively affected in any way by this study. https://www.nhs.uk/mental-health/nhs-voluntary-charity-services/charity-and-voluntary-services/get-help-from-mental-health-helplines/

Mind – 'How can I help myself?' This page includes information on how to support yourself when experiencing mental health problems. https://www.mind.org.uk/information-support/types-of-mental-health-problems/mental-health-problems-introduction/self-care/

Page Break

PIS 2

How will the information I provide be kept secure and confidential?

We will not ask you to give any identifying information during the online survey. You will not be identified by the data that we collect, on any material that results from the data collected, or in any write-up of the research. We will store research data on a password-protected system that is only accessible by the researcher, and my supervisor. Data will be transferred using secure UEL emails. The data will only be seen by myself, my supervisor, and examiners.

For the purposes of data protection, the University of East London is the Data Controller for the personal information processed as part of this research project. The University processes this information under the 'public task' condition contained in the General Data Protection Regulation (GDPR). Where the University processes particularly sensitive data (known as 'special category data' in the GDPR), it does so because the processing is necessary for archiving purposes in the public interest, or scientific and historical research purposes or statistical purposes. The University will ensure that the personal data it processes is held securely and processed in accordance with the GDPR and the Data Protection Act 2018. For more information about how the University processes personal data please see www.uel.ac.uk/about/about-uel/governance/information-assurance/data-protection

What will happen to the results of the research?

The research will be written up as a thesis and submitted for assessment. The thesis will be publicly available on UEL's online Repository. Findings may also be disseminated through other forms of media, such as journal articles. In all material produced, your identity will remain anonymous, in that, it will not be possible to identify you personally.

You will be given the opportunity to provide your email address if you wish to receive a summary of the research findings once the study has been completed.

Anonymised research data will be securely stored by Professor John Read

(Research Supervisor) for a maximum of 3 years, following which all data will be deleted.

Who has reviewed the research?

My research has been approved by the School of Psychology Ethics Committee. This means that the Committee's evaluation of this ethics application has been guided by the standards of research ethics set by the British Psychological Society.

Who can I contact if I have any questions/concerns?

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me.

Katie McLaren, Email: u2195532@uel.ac.uk

If you have any questions or concerns about how the research has been conducted, please contact my research supervisor, Professor John Read. School of Psychology, University of East London, Water Lane, London E15 4LZ,
Email: j.read2@uel.ac.uk

or

Chair of School Ethics Committee: Dr Trishna Patel, School of Psychology, University of East London, Water Lane, London E15 4LZ.
(Email: t.patel@uel.ac.uk)

Thank you for taking the time to read this information sheet

Download PIS Please click on the file name below if you want to download the participant information sheet.

[Participant Information Sheet]

End of Block: Information sheet

Start of Block: Consent form

Consent form

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Exploring Clients' Experiences of Disclosing Childhood Adversity to Mental Health Professionals

Contact person: Katie McLaren (Trainee Clinical Psychologist)
Email: u2195532@uel.ac.uk

Consent form Q1 I confirm that I have read the participant information sheet dated 24/01/2023 (version 1) for the above study and that I have been given the option to download a copy to keep.

○ Yes (1)

○ No (2)

Consent form Q2 I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

○ Yes (1)

○ No (2)

Consent form Q3 I understand that my participation in the study is voluntary and that I may withdraw within three weeks of completing the survey, without explanation or disadvantage.

○ Yes (1)

○ No (2)

Consent form Q4 I understand that if I withdraw during the study, my data will not be used.

○ Yes (1)

○ No (2)

Consent form Q5 I understand that I have 3 weeks from the date of completing the survey to withdraw my data from the study.

○ Yes (1)

○ No (2)

Participant ID If you wish to withdraw your data from the study, please send me an email quoting your participant ID at the email address above.
Here is your Participant ID: ${e://Field/Random%20ID}

Consent form Q6 I understand that the data that is collected from the research is anonymous, will be securely stored, and remain confidential. Only the research team will have access to this information, to which I give my permission.

○ Yes (1)

○ No (2)

Consent form Q7 It has been explained to me what will happen to the data once the research has been completed.

○ Yes (1)

○ No (2)

Consent form Q8 I understand that short, anonymised quotes from my survey may be used in material such as conference presentations, reports, articles in academic journals resulting from the study and that these will not personally identify me.

○ Yes (1)

○ No (2)

Consent form Q9 I agree to take part in the above study.

○ Yes (1)

○ No (2)

End of Block: Consent form

Start of Block: Consent form refusal message

Q18

You did not give full consent to take part in this study, therefore, you cannot take part in this study.
Thank you for your interest in this study!

End of Block: Consent form refusal message

Start of Block: Demographics

Q1 Are you between the ages of 18 and 40?

○ Yes (1)

○ No (2)

Q2 Please specify your age

____

Q3 Do you currently live in Great Britain?

- ○ No (1)
- ○ Yes (2)

Q4 Our experiences in childhood can have an impact on our physical and psychological health in the future, even if these experiences happened a long time ago.

Experiences of childhood adversity are very common. Childhood adversity can be described as the experience of stressful events that had/still have an impact on your physical and/or psychological wellbeing, such as childhood abuse, neglect, poverty, bullying, discrimination, and so on.

Would you class yourself as having experienced childhood adversity?

- ○ Yes (1)
- ○ No (2)
- ○ I prefer not to say (3)

Q5 Have you sought support from mental health services in the past 20 years?
E.g. NHS mental health services, non-profit organisations, charities, private mental health treatment.

- ○ No (1)
- ○ Yes (2)

Q5A Were you seen as an inpatient or outpatient?

○ Inpatient (1)

○ Outpatient (2)

○ Other (3)

○ Not sure (4)

Q5B How long did you receive treatment with the mental health service for?

○ Less than a month (1)

○ Between one to six months (2)

○ between six months to a year (3)

○ Over a year (4)

Page Break

Q6 How do you describe yourself?

- ○ Male (1)
- ○ Female (2)
- ○ Non-binary / third gender (3)
- ○ Prefer not to say (4)
- ○ Prefer to self-describe (5)

Q6A Please self-describe your gender

____

Q7 What best describes your ethnic origin?

▼ Asian or Asian British (1) ... I prefer not to say (6)

Q8 What is the highest level of education you have completed?

○ No schooling completed (1)

○ Primary school (2)

○ Secondary school up to 16 years (3)

○ Higher or secondary or further education (A-Levels, BTEC, etc) (4)

○ College or University (5)

○ Post-graduate degree (6)

○ I prefer not to say (7)

Q9 What is your current employment status?

▼ Unemployed (1) ... Other (5)

End of Block: Demographics

Start of Block: Exclusion Criteria

Q84

You do not meet the requirements to take part in this study, therefore, you cannot take part in this study.
Thank you for your interest in this study!

End of Block: Exclusion Criteria

Start of Block: Expanded ACE Questionnaire

Q11a The following questions will ask you about some common experiences of childhood adversity.

Page Break

Q11 While you were growing up how often did a parent, step-parent, or another adult living in your home swear at you, insult you, or put you down?

○ Never (1)

○ Once (2)

○ More than once (3)

Q12 While you were growing up how often did a parent, step-parent, or another adult living in your home act in a way that made you afraid that you would be physically hurt?

○ Never (1)

○ Once (2)

○ More than once (3)

Q13 While you were growing up did a parent, step-parent, or another adult living in your home push, grab, shove, or slap you?

○ Never (1)

○ Once (2)

○ More than once (3)

Q14 While you were growing up did a parent, step-parent, or another adult living in your home hit you so hard that you had marks or were injured?

○ Never (1)

○ Once (2)

○ More than once (3)

Q15 During the first 18 years of life, did an adult or older relative, family friend, or stranger who was at least five years older than yourself ever touch or fondle you in a sexual way or have you touch their body in a sexual way?

○ Yes (1)

○ No (2)

Q16 and/or attempt to have or actually have any type of sexual intercourse, oral, anal or vaginal with you?

○ Yes (1)

○ No (2)

Page Break

Q17 There was someone in your life who helped you feel important or special.

○ Never true (1)

○ Rarely true (2)

○ Sometimes true (3)

○ Often true (4)

○ Very often true (5)

Q18 Your family sometimes cut the size of meals or skipped meals because there was not enough money in the budget for food.

- ○ Never true (1)
- ○ Rarely true (2)
- ○ Sometimes true (3)
- ○ Often true (4)
- ○ Very often true (5)

Q19 How often, if ever, did you see or hear in your home a parent, step-parent, or another adult who was helping to raise you being slapped, kicked, punched, or beaten up?

- ○ Never (1)
- ○ Once (2)
- ○ A few times (3)
- ○ Many times (4)

Q20 How often, if ever, did you see or hear in your home a parent, step-parent, or another adult who was helping to raise you being hit or cut with an object, such as a stick, cane, bottle, club, knife or gun?

○ Never (1)

○ Once (2)

○ A few times (3)

○ Many times (4)

Q21 Did you live with anyone who was a problem drinker or alcoholic?

○ Yes (1)

○ No (2)

Q22 Did you live with anyone who used illegal street drugs or who abused prescription medications?

○ Yes (1)

○ No (2)

Q23 While you were growing up, did you live with anyone who was depressed or mentally ill?

○ Yes (1)

○ No (2)

Q24 Did you live with anyone who was suicidal?

○ Yes (1)

○ No (2)

Q25 Were your parents were ever separated or divorced?

○ Yes (1)

○ No (2)

Q26 Did you live with anyone who served time or was sentenced to serve time in a prison, jail, or other correctional facility?

○ Yes (1)

○ No (2)

Q27 How often, if ever, did you see or hear someone being beaten up, stabbed, or shot in real life?

○ Never (1)

○ Once (2)

○ A few times (3)

○ Many times (4)

Q28 While you were growing up, how often did you feel that you were treated badly or unfairly because of your race or ethnicity?

○ Never true (1)

○ Rarely true (2)

○ Sometimes true (3)

○ Often true (4)

○ Very often true (5)

Q29 Did you feel safe in your neighbourhood?

- ○ None of the time (1)
- ○ Some of the time (2)
- ○ Most of the time (3)
- ○ All the time (4)

Q30 Did you feel people in your neighbourhood looked out for each other, stood up for each other, and could be trusted?

- ○ None of the time (1)
- ○ Some of the time (2)
- ○ Most of the time (3)
- ○ All the time (4)

Q31 How often were you bullied by a peer or classmate?

- ○ None of the time (1)
- ○ Some of the time (2)
- ○ Most of the time (3)
- ○ All the time (4)

Q32 Were you ever in foster care?

○ Yes (1)

○ No (2)

Page Break

Q33 Have you ever told mental health professionals about your experience of childhood adversity?

○ Yes (1)

○ No (2)

End of Block: Expanded ACE Questionnaire

Start of Block: Told MHPs

Q33.1 What helped you to feel able to share your experience of childhood adversity?

Please write as much or as little as you would like

____

Q33.2 What was helpful and/or unhelpful during the process of telling the mental health professional about your experience of childhood adversity?

____

Q33.3 Were there any barriers to telling the mental health professional about your experience of childhood adversity?

____

Q33.4 Was there anything that could have been done differently by the mental health professional to help you to share your experience of childhood adversity?

____

End of Block: Told MHPs

Start of Block: Did not tell MHPs

Q34 Did you want to tell mental health professionals about your experience of childhood adversity?

○ Yes (1)

○ No (2)

Q34.1 Would you like to make any comments regarding this?

____

Skip To: End of Survey If Condition: Would you like to make any ... Is Empty. Skip to: End of Survey.

Q34.2 What made you decide not to tell mental health professionals about your experience of childhood adversity?

____

Q34.3 Were there any barriers to telling the mental health professional about your experience of childhood adversity?

____

Q34.4 Was there anything that could have been done differently by mental health professionals to help you to share your experience of childhood adversity?

____

End of Block: Did not tell MHPs

Start of Block: Did MHP ask?

Q35 Did anyone from mental health services ever ask if you had experienced childhood adversity?

○ Yes (1)

○ No (2)

Q35.1 How did you feel about being asked about childhood adversity?

____

Q35.2 Mental health professionals asked in a sensitive manner.

- ○ Strongly disagree (1)
- ○ Somewhat disagree (2)
- ○ Neither agree nor disagree (3)
- ○ Somewhat agree (4)
- ○ Strongly agree (5)

Q35.3 How helpful was the response from the mental health service/professional?

- ○ Not at all helpful (1)
- ○ Somewhat unhelpful (2)
- ○ Neither helpful nor unhelpful (3)
- ○ Somewhat helpful (4)
- ○ Helpful (5)
- ○ Very helpful (6)

Q35.4 The mental health professional/service listened to and acknowledged what I was saying.

○ Strongly disagree (1)

○ Somewhat disagree (2)

○ Neither agree nor disagree (3)

○ Somewhat agree (4)

○ Strongly agree (5)

Q35.5 I was satisfied with how the service responded to me when sharing my experience of childhood adversity.

○ Strongly disagree (1)

○ Somewhat disagree (2)

○ Neither agree nor disagree (3)

○ Somewhat agree (4)

○ Strongly agree (5)

Q35.6 How did you feel when you were not asked about your experience of childhood adversity?

____

Q36 I got the help that I needed from the mental health professional/s and the mental health service.

○ Strongly disagree (1)

○ Somewhat disagree (2)

○ Neither agree nor disagree (3)

○ Somewhat agree (4)

○ Strongly agree (5)

End of Block: Did MHP ask?

Start of Block: Ending

Q37 If you would like to receive a written summary of the results following completion of the research, please provide your email address.

____

Q38 If you would be happy for us to contact you for an online interview about your experience, please provide your email address.

____

End of Block: Ending

Start of Block: Debrief sheet

PARTICIPANT DEBRIEF SHEET

Exploring Clients' Experiences of Childhood Adversity to Mental Health Professionals

Thank you for participating in my research study on people's experiences of sharing experiences of childhood adversity with mental health professionals. This document offers information that may be relevant in light of you having now taken part.

How will my data be managed?

The University of East London is the Data Controller for the personal information processed as part of this research project. The University will ensure that the personal data it processes is held securely and processed in accordance with the GDPR and the Data Protection Act 2018. More detailed information is available in the Participant Information Sheet, which you received when you agreed to take part in the research.

What will happen to the results of the research?

The research will be written up as a thesis and submitted for assessment. The thesis will be publicly available on UEL's online Repository. Findings may also be disseminated through other forms of media, such as journal articles. In all material produced, your identity will remain anonymous, in that, it will not be possible to identify you personally.

You will be given the opportunity to provide your email address at the end of the survey, if you wish to receive a summary of the results once the research has been completed.

Anonymised research data will be securely stored by Professor John Read, for a maximum of 3 years, following which all data will be deleted.

What if I have been adversely affected by taking part?

It is not anticipated that you will have been adversely affected by taking part in the research, and all reasonable steps have been taken to minimise distress or harm of any kind. Nevertheless, it is possible that your participation – or its after-effects – may have been challenging, distressing or uncomfortable in some way. If you have been affected in any of those ways, you may find the following resources/services helpful in relation to obtaining information and support:

The NHS provides a list of useful helplines if you find yourself negatively affected in any way by this study. https://www.nhs.uk/mental-health/nhs-voluntary-charity-services/charity-and-voluntary-services/get-help-from-mental-health-helplines/

Mind – How can I help myself? This page includes information on how to support yourself when experiencing mental health problems. https://www.mind.org.uk/information-support/types-of-mental-health-problems/mental-health-problems-introduction/self-care/

Who can I contact if I have any questions/concerns?
If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me.

Katie McLaren – Email: u2195532@uel.ac.uk

If you have any questions or concerns about how the research has been conducted, please contact my research supervisor, Professor John Read. School of Psychology, University of East London, Water Lane, London E15 4LZ,
Email: j.read2@uel.ac.uk

or

Chair of School Ethics Committee: Dr Trishna Patel, School of Psychology, University of East London, Water Lane, London E15 4LZ.
(Email: t.patel@uel.ac.uk)

Thank you for taking part in my study.

End of Block: Debrief sheet

Appendix D: Ethics Application

UNIVERSITY OF EAST LONDON
School of Psychology

APPLICATION FOR RESEARCH ETHICS APPROVAL FOR RESEARCH INVOLVING HUMAN PARTICIPANTS
(Updated October 2021)

FOR BSc RESEARCH;
MSc/MA RESEARCH;
PROFESSIONAL DOCTORATE RESEARCH IN CLINICAL, COUNSELLING & EDUCATIONAL PSYCHOLOGY

Section 1 – Guidance on Completing the Application Form
(please read carefully)

1.1	Before completing this application, please familiarise yourself with: ▪ British Psychological Society's Code of Ethics and Conduct ▪ UEL's Code of Practice for Research Ethics ▪ UEL's Research Data Management Policy ▪ UEL's Data Backup Policy
1.2	Email your supervisor the completed application and all attachments as ONE WORD DOCUMENT. Your supervisor will look over your application and provide feedback.
1.3	When your application demonstrates a sound ethical protocol, your supervisor will submit it for review.
1.4	Your supervisor will let you know the outcome of your application. Recruitment and data collection must **NOT** commence until your ethics application has been approved, along with other approvals that may be necessary (see section 7).
1.5	Research in the NHS: ▪ If your research involves patients or service users of the NHS, their relatives or carers, as well as those in receipt of services provided under contract to the NHS, you will need to apply for HRA approval/NHS permission (through IRAS). You DO NOT need to apply to the School of Psychology for ethical clearance. ▪ Useful websites: https://www.myresearchproject.org.uk/Signin.aspx

	https://www.hra.nhs.uk/approvals-amendments/what-approvals-do-i-need/hra-approval/ ▪ If recruitment involves NHS staff via the NHS, an application will need to be submitted to the HRA in order to obtain R&D approval. This is in addition to separate approval via the R&D department of the NHS Trust involved in the research. UEL ethical approval will also be required. ▪ HRA/R&D approval is not required for research when NHS employees are not recruited directly through NHS lines of communication (UEL ethical approval is required). This means that NHS staff can participate in research without HRA approval when a student recruits via their own social/professional networks or through a professional body such as the BPS, for example. ▪ The School strongly discourages BSc and MSc/MA students from designing research that requires HRA approval for research involving the NHS, as this can be a very demanding and lengthy process.
1.6	If you require Disclosure Barring Service (DBS) clearance (see section 6), please request a DBS clearance form from the Hub, complete it fully, and return it to applicantchecks@uel.ac.uk. Once the form has been approved, you will be registered with GBG Online Disclosures and a registration email will be sent to you. Guidance for completing the online form is provided on the GBG website: https://fadv.onlinedisclosures.co.uk/Authentication/Login You may also find the following website to be a useful resource: https://www.gov.uk/government/organisations/disclosure-and-barring-service
1.7	Checklist, the following attachments should be included if appropriate: ▪ Study advertisement ▪ Participant Information Sheet (PIS) ▪ Participant Consent Form ▪ Participant Debrief Sheet ▪ Risk Assessment Form/Country-Specific Risk Assessment Form (see section 5) ▪ Permission from an external organisation (see section 7) ▪ Original and/or pre-existing questionnaire(s) and test(s) you intend to use ▪ Interview guide for qualitative studies ▪ Visual material(s) you intend showing participants

Section 2 – Your Details

2.1	**Your name:**	**Katie McLaren**
2.2	**Your supervisor's name:**	**John Read**
2.3	**Name(s) of additional UEL supervisors:**	**Trishna Patel** 3rd supervisor (if applicable)
2.4	**Title of your programme:**	**Professional Doctorate in Clinical Psychology**
2.5	**UEL assignment submission date:**	Initial submission date Re-sit date (if applicable)

Section 3 – Project Details		
Please give as much detail as necessary for a reviewer to be able to fully understand the nature and purpose of your research.		
3.1	**Study title:** Please note - If your study requires registration, the title inserted here must be the same as that on PhD Manager	**Exploring Clients' Experiences of Disclosing Childhood Adversity to Mental Health Professionals**
3.2	**Summary of study background and aims (using lay language):**	**There is an established link between experiences of childhood adversity and a wide range of adult mental and physical health difficulties (Juwariah et al., 2022; Nelson et al., 2020; Sheffler et al., 2020), in addition to evidence that those accessing mental health services have experienced high rates of childhood adversity (Bentall et al., 2014). Disclosure rates, and experiences of disclosure of childhood adversity is widely underreported. Most existing research explores barriers to discussing childhood adversity from the perspective of mental health professionals. The current research seeks to explore the barriers that individuals with lived experience face during disclosure of childhood adversity to mental health professionals. It is hoped that exploring individuals' experiences will inform existing research surrounding barriers to disclosure, in addition to informing services around potential barriers that individuals may face when disclosing. The findings of the research may further inform implementation of trauma-informed care within services and organisations.**
3.3	**Research question(s):**	**What are the barriers that individuals with experience of childhood adversity face when disclosing their experience to mental health professionals?** **What do individuals believe facilitated or disrupted disclosure of childhood adversity to mental health professionals?** **Are there similarities and/or differences in the experience of disclosure for individuals**

		based upon the type of childhood adversity experienced?
3.4	**Research design:**	**The research will use mixed methodology. Quantitative and qualitative analysis will be conducted using data collected from an online, anonymous survey. The survey will include closed questions exploring demographics and instances of childhood adversity, in addition to open questions that will allow the participant to detail their experiences of disclosure/non-disclosure.**
3.5	**Participants:** Include all relevant information including inclusion and exclusion criteria	**The criteria for participation will be adults aged between 18 and 40 who have experienced childhood adversity and have sought support from mental health services in the past 20 years. It is hoped that we will be able to recruit 100+ participants to enable a content analysis.**
3.6	**Recruitment strategy:** Provide as much detail as possible and include a backup plan if relevant	**Participants will be recruited via an online survey that will be circulated by an organisation that supports survivors of childhood adversity. Participants will be informed of the anonymous online survey directly through the organisation, via social media. Three separate organisations have confirmed that following evidence of ethical approval and approval of the survey, they would be willing to circulate the survey to their members. Initially, one organisation (XXXX) would be used. If more participants are required, the following two organisations can be contacted (XXXX AND XXXX) Should this initial recruitment strategy fail, several social media support groups have been identified as possible ways to access appropriate participants.**
3.7	**Measures, materials or equipment:** Provide detailed information, e.g., for measures, include scoring instructions, psychometric properties, if freely available, permissions required, etc.	**Qualtrics will be used to create and share the online survey. The Expanded ACE Questionnaire (Cronholm et al., 2015) measure will be used.**
3.8	**Data collection:**	**Data will be collected via an online survey on Qualtrics. The information sheet will be**

	Provide information on how data will be collected from the point of consent to debrief	**presented on the first page of the online survey. On the second page, participants will need to fill in a consent form. Participants will be able to fill in the survey only if they give consent. They will then answer the survey on the following pages. If participants do not provide consent, then they will be taken to the final page of the survey. The debrief form will be presented on the last page of the online survey.**	
3.9	**Will you be engaging in deception?**	**YES** ☐	**NO** ☒
	If yes, what will participants be told about the nature of the research, and how/when will you inform them about its real nature?	**NA**	
3.10	**Will participants be reimbursed?**	**YES** ☐	**NO** ☒
	If yes, please detail why it is necessary.	**NA**	
	How much will you offer? Please note - This must be in the form of vouchers, not cash.	**NA**	
3.11	**Data analysis:**	**The data will be analysed using content analysis.**	

Section 4 – Confidentiality, Security and Data Retention

It is vital that data are handled carefully, particularly the details about participants. For information in this area, please see the UEL guidance on data protection, and also the UK government guide to data protection regulations.

If a Research Data Management Plan (RDMP) has been completed and reviewed, information from this document can be inserted here.

4.1	**Will the participants be anonymised at source?**	**YES** ☒	**NO** ☐
	If yes, please provide details of how the data will be anonymised.	**Participants will not be asked to provide their name or other identifying details when completing the survey. They will be given a participant ID which will allow them to withdraw their data from the study if they wish to do so. This participant ID will enable the researcher to identify and delete data if required. Participants will have the option to provide their email address to be sent a**	

		summary of the results upon completion of the research.	
4.2	**Are participants' responses anonymised or are an anonymised sample?**	**YES** X☐	**NO** ☐
	If yes, please provide details of how data will be anonymised (e.g., all identifying information will be removed during transcription, pseudonyms used, etc.).	**Participants will not be asked to provide their name or other identifying details when completing the survey.**	
4.3	**How will you ensure participant details will be kept confidential?**	**Any personal data that is collected will be held securely and processed in accordance with the UK GDPR and the Data Protection Act 2018. Participants will not be identified by the data collected, or any material resulting from the data collected, or in any write-up of the research.**	
4.4	**How will data be securely stored and backed up during the research?** Please include details of how you will manage access, sharing and security	**The data will be stored on my UEL's password protected OneDrive account in a folder that is not synchronised on any devices. Data will be sent to the supervisor as a backup during the study and stored on the supervisor's OneDrive account.**	
4.5	**Who will have access to the data and in what form?** (e.g., raw data, anonymised data)	**My supervisor and I will have access to the anonymous, raw data. Examiners may also have access to the data if requested.**	
4.6	**Which data are of long-term value and will be retained?** (e.g., anonymised interview transcripts, anonymised databases)	**The anonymised dataset is of long-term value.**	
4.7	**What is the long-term retention plan for this data?**	**Anonymised research data will be securely stored on my supervisor's UEL password-protected OneDrive account for a maximum of 3 years, following which, all data will be deleted.**	
4.8	**Will anonymised data be made available for use in future research by other researchers?**	**YES** ☐	**NO** ☒
	If yes, have participants been informed of this?	**YES** ☐	**NO** ☐
4.9	**Will personal contact details be retained to contact participants in the future for other research studies?**	**YES** ☐	**NO** ☒

	If yes, have participants been informed of this?	**YES** ☐	**NO** ☐

Section 5 – Risk Assessment

If you have serious concerns about the safety of a participant, or others, during the course of your research please speak with your supervisor as soon as possible. If there is any unexpected occurrence while you are collecting your data (e.g., a participant or the researcher injures themselves), please report this to your supervisor as soon as possible.

5.1	**Are there any potential physical or psychological risks to participants related to taking part?** (e.g., potential adverse effects, pain, discomfort, emotional distress, intrusion, etc.)	**YES** ☒	**NO** ☐
	If yes, what are these, and how will they be minimised?	**There are rarely potential physical risks for our participants. However, there are almost always potential psychological risks for the participants (e.g., emotional impact of taking part in a study about their past traumatic experiences). The information sheet will alert participants that questions within the survey will be of a sensitive nature and may bring up difficult feelings. The debrief sheet will acknowledge that some of the questions may have resulted in difficult feelings and may have had an emotional impact on the participant. Appropriate support services will be listed in material provided to participants.**	
5.2	**Are there any potential physical or psychological risks to you as a researcher?**	**YES** ☒	**NO** ☐
	If yes, what are these, and how will they be minimised?	**There are no potential physical or psychological risks for the researcher, except for the risk to the researcher's online identity.**	
5.3	**If you answered yes to either 5.1 and/or 5.2, you will need to complete and include a General Risk Assessment (GRA) form (signed by your supervisor). Please confirm that you have attached a GRA form as an appendix:**	**YES** ☒	

5.4	**If necessary, have appropriate support services been identified in material provided to participants?**	**YES** ☒	**NO** ☐	**N/A** ☐
5.5	**Does the research take place outside the UEL campus?**	**YES** ☒	**NO** ☐	
	If yes, where?	**Online**		
5.6	**Does the research take place outside the UK?**	**YES** ☐	**NO** ☒	
	If yes, where?	Please state the country and other relevant details		
	If yes, in addition to the General Risk Assessment form, a Country-Specific Risk Assessment form must also be completed and included (available in the Ethics folder in the Psychology Noticeboard). Please confirm a Country-Specific Risk Assessment form has been attached as an appendix. Please note - A Country-Specific Risk Assessment form is not needed if the research is online only (e.g., Qualtrics survey), regardless of the location of the researcher or the participants.	**YES** ☐		
5.7	**Additional guidance:** ▪ For assistance in completing the risk assessment, please use the AIG Travel Guard website to ascertain risk levels. Click on ‘sign in’ and then ‘register here’ using policy # 0015865161. Please also consult the Foreign Office travel advice website for further guidance. ▪ For on campus students, once the ethics application has been approved by a reviewer, all risk assessments for research abroad must then be signed by the Director of Impact and Innovation, Professor Ian Tucker (who may escalate it up to the Vice Chancellor). ▪ For distance learning students conducting research abroad in the country where they currently reside, a risk assessment must also be carried out. To minimise risk, it is recommended that such students only conduct data collection online. If the project is deemed low risk, then it is not necessary for the risk assessment to be signed by the Director of Impact and Innovation. However, if not deemed low risk, it must be signed by the Director of Impact and Innovation (or potentially the Vice Chancellor).			

	▪ Undergraduate and M-level students are not explicitly prohibited from conducting research abroad. However, it is discouraged because of the inexperience of the students and the time constraints they have to complete their degree.

Section 6 – Disclosure and Barring Service (DBS) Clearance

6.1	**Does your research involve working with children (aged 16 or under) or vulnerable adults (*see below for definition)?** If yes, you will require Disclosure Barring Service (DBS) or equivalent (for those residing in countries outside of the UK) clearance to conduct the research project	**YES** ☐	**NO** ☒
	* You are required to have DBS or equivalent clearance if your participant group involves: (1) Children and young people who are 16 years of age or under, or (2) 'Vulnerable' people aged 16 and over with particular psychiatric diagnoses, cognitive difficulties, receiving domestic care, in nursing homes, in palliative care, living in institutions or sheltered accommodation, or involved in the criminal justice system, for example. Vulnerable people are understood to be persons who are not necessarily able to freely consent to participating in your research, or who may find it difficult to withhold consent. If in doubt about the extent of the vulnerability of your intended participant group, speak with your supervisor. Methods that maximise the understanding and ability of vulnerable people to give consent should be used whenever possible.		
6.2	**Do you have DBS or equivalent (for those residing in countries outside of the UK) clearance to conduct the research project?**	**YES** ☐	**NO** ☐
6.3	**Is your DBS or equivalent (for those residing in countries outside of the UK) clearance valid for the duration of the research project?**	**YES** ☐	**NO** ☐
6.4	**If you have current DBS clearance, please provide your DBS certificate number:**	Please enter your DBS certificate number	

	If residing outside of the UK, please detail the type of clearance and/or provide certificate number.	Please provide details of the type of clearance, including any identification information such as a certificate number
6.5	**Additional guidance:** ▪ If participants are aged 16 or under, you will need two separate information sheets, consent forms, and debrief forms (one for the participant, and one for their parent/guardian). ▪ For younger participants, their information sheets, consent form, and debrief form need to be written in age-appropriate language.	

Section 7 – Other Permissions

7.1	**Does the research involve other organisations (e.g., a school, charity, workplace, local authority, care home, etc.)?**	**YES** ☒	**NO** ☐
	If yes, please provide their details.	**XXXX**	
	If yes, written permission is needed from such organisations (i.e., if they are helping you with recruitment and/or data collection, if you are collecting data on their premises, or if you are using any material owned by the institution/organisation). Please confirm that you have attached written permission as an appendix.	**YES** ☒	
7.2	**Additional guidance:** ▪ Before the research commences, once your ethics application has been approved, please ensure that you provide the organisation with a copy of the final, approved ethics application or approval letter. Please then prepare a version of the consent form for the organisation themselves to sign. You can adapt it by replacing words such as 'my' or 'I' with 'our organisation' or with the title of the organisation. This organisational consent form must be signed before the research can commence. ▪ If the organisation has their own ethics committee and review process, a SREC application and approval is still required. Ethics approval from SREC can be gained before approval from another research ethics committee is obtained. However, recruitment and data collection are NOT to commence until your research has been approved by the School and other ethics committee/s.		

Section 8 – Declarations

8.1	**Declaration by student. I confirm that I have discussed the ethics and feasibility of this research proposal with my supervisor:**	**YES** ☒
8.2	**Student's name:** (Typed name acts as a signature)	**Katie McLaren**
8.3	**Student's number:**	**U2195532**
8.4	**Date:**	**24/01/2023**
Supervisor's declaration of support is given upon their electronic submission of the application		

Ethics Form Appendix A: Participant Information Sheet (PIS) template

Version: 1
Date: 24/01/2023

PARTICIPANT INFORMATION SHEET

Exploring Clients' Experiences of Disclosing Childhood Adversity to Mental Health Professionals

Contact person: Katie McLaren (Trainee Clinical Psychologist)
Email: u2195532@uel.ac.uk

You are being invited to participate in a research study. Before you decide whether to take part or not, please carefully read through the following information which outlines what your participation would involve. Feel free to talk with others about the study (e.g., friends, family, etc.) before making your decision. If anything is unclear or you have any questions, please do not hesitate to contact me on the above email.

Who am I?

My name is Katie McLaren. I am a postgraduate student in the School of Psychology at the University of East London (UEL) and am studying for a professional doctorate in clinical psychology. As part of my studies, I am conducting the research that you are being invited to participate in.

What is the purpose of the research?

I am conducting research into the experiences that people have when they attempt to tell a mental health professional about their experience of childhood adversity. Childhood adversity is the experience of stressful events that had, and may still have, an impact on your physical and/or psychological wellbeing (e.g. childhood abuse, neglect, poverty, and so on).

The aim of the study is to understand the barriers that people might face when telling mental health professionals about their experiences of childhood adversity, in addition to what people found helpful and/or unhelpful when sharing these experiences. I am also interested in the similarities and differences of the experience of telling (or not telling) mental health professionals about childhood adversity, based on what the childhood adversity was. I hope that the findings of the research can be used to improve mental health professionals' understanding of how they can help people to share their experiences of childhood adversity and subsequently access the psychological support that they may need.

Why have I been invited to take part?

To address the study aims, I am inviting people who have had experience of childhood adversity to take part in my research. If you are between the ages of 18 and 40, have experienced childhood adversity, and have sought support from mental health services in the past 20 years, you are eligible to take part in the study.

It is entirely up to you whether you take part or not, participation is voluntary.

What will I be asked to do if I agree to take part?

If you agree to take part, you will be asked to complete an anonymous, online survey, that will ask you several questions about your demographics, early childhood experiences and your experience of telling (or not telling) these experiences to mental health professionals. You will also have the opportunity to provide your email address if you are happy for us to contact you for an interview about your experiences.

There are approximately 50 questions to answer. We estimate that the study may take approximately 30 minutes to complete. Some of the questions will be short and quick to answer. Some questions (those asking you to describe your past experiences) may take slightly longer to answer.

Can I change my mind?

Yes, you can change your mind and withdraw without explanation, disadvantage or consequence, within three weeks of completing the survey. If you would like to withdraw from the survey whilst completing it, you can do so by closing the survey. If you withdraw, your data will not be used as part of the research.

Separately, you can also request to withdraw your data from being used even after you have taken part in the study, provided that this request is made within three weeks of the data being collected (after which point the data analysis will begin, and withdrawal will not be possible).

Are there any disadvantages to taking part?

It is possible that answering questions about difficult past experiences may result in some distressing feelings arising. Please do not continue to answer questions in the survey if they are causing you significant emotional distress.

The NHS provides a list of useful helplines if you find yourself negatively affected in any way by this study. https://www.nhs.uk/mental-health/nhs-voluntary-charity-services/charity-and-voluntary-services/get-help-from-mental-health-helplines/

Mind – How can I help myself? This page includes information on how to support yourself when experiencing mental health problems. https://www.mind.org.uk/information-support/types-of-mental-health-problems/mental-health-problems-introduction/self-care/

How will the information I provide be kept secure and confidential?

We will not ask you to give any identifying information during the online survey. You will not be identified by the data that we collect, on any material that results from the data collected, or in any write-up of the research. We will store research data on a password-protected system that is only accessible by the researcher, and my supervisor. Data will be transferred using secure UEL emails. The data will only be seen by myself, my supervisor, and examiners.

For the purposes of data protection, the University of East London is the Data Controller for the personal information processed as part of this research project. The University processes this information under the ‘public task’ condition contained in the General Data Protection Regulation (GDPR). Where the University processes particularly sensitive data (known as ‘special category data’ in the GDPR), it does so because the processing is necessary for archiving purposes in the public interest, or scientific and historical research purposes or statistical purposes. The University will ensure that the personal data it processes is held securely and processed in accordance with the GDPR and the Data Protection Act 2018. For more information about how the University processes personal data please see www.uel.ac.uk/about/about-uel/governance/information-assurance/data-protection

What will happen to the results of the research?

The research will be written up as a thesis and submitted for assessment. The thesis will be publicly available on UEL’s online Repository. Findings may also be disseminated through other forms of media, such as journal articles. In all material produced, your identity will remain anonymous, in that, it will not be possible to identify you personally.

You will be given the opportunity to provide your email address if you wish to receive a summary of the research findings once the study has been completed.

Anonymised research data will be securely stored by Professor John Read (Research Supervisor) for a maximum of 3 years, following which all data will be deleted.

Who has reviewed the research?

My research has been approved by the School of Psychology Ethics Committee. This means that the Committee’s evaluation of this ethics application has been guided by the standards of research ethics set by the British Psychological Society.

Who can I contact if I have any questions/concerns?

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me.

Katie McLaren, Email: u2195532@uel.ac.uk

If you have any questions or concerns about how the research has been conducted, please contact my research supervisor, Professor John Read. School of Psychology, University of East London, Water Lane, London E15 4LZ,
Email: j.read2@uel.ac.uk

or

Chair of School Ethics Committee: Dr Trishna Patel, School of Psychology,
University of East London, Water Lane, London E15 4LZ.
(Email: t.patel@uel.ac.uk)

Thank you for taking the time to read this information sheet

Ethics Form Appendix B: Consent Form template

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Exploring Clients' Experiences of Disclosing Childhood Adversity to Mental Health Professionals

Contact person: Katie McLaren (Trainee Clinical Psychologist)
Email: u2195532@uel.ac.uk

	Please initial
I confirm that I have read the participant information sheet dated 24/01/2023 (version 1) for the above study and that I have been given a copy to keep.	
I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	

I understand that my participation in the study is voluntary and that I may withdraw within three weeks of completing the survey, without explanation or disadvantage.	
I understand that if I withdraw during the study, my data will not be used.	
I understand that I have 3 weeks from the date of the survey to withdraw my data from the study.	
I understand that the data that is collected from the research is anonymous, will be securely stored, and remain confidential. Only the research team will have access to this information, to which I give my permission.	
It has been explained to me what will happen to the data once the research has been completed.	
I understand that short, anonymised quotes from my survey may be used in material such as conference presentations, reports, articles in academic journals resulting from the study and that these will not personally identify me.	
I agree to take part in the above study.	

Ethics Form Appendix C: Participant Debrief Sheet template

University of
East London

PARTICIPANT DEBRIEF SHEET

Exploring Clients' Experiences of Childhood Adversity to Mental Health Professionals

Thank you for participating in my research study on people's experiences of sharing experiences of childhood adversity with mental health professionals. This document offers information that may be relevant in light of you having now taken part.

How will my data be managed?

The University of East London is the Data Controller for the personal information processed as part of this research project. The University will ensure that the personal data it processes is held securely and processed in accordance with the GDPR and the Data Protection Act 2018. More detailed information is available in the Participant Information Sheet, which you received when you agreed to take part in the research.

What will happen to the results of the research?

The research will be written up as a thesis and submitted for assessment. The thesis will be publicly available on UEL's online Repository. Findings may also be disseminated through other forms of media, such as journal articles. In all material produced, your identity will remain anonymous, in that, it will not be possible to identify you personally.

You will be given the opportunity to provide your email address at the end of the survey, if you wish to receive a summary of the results once the research has been completed.

Anonymised research data will be securely stored by Professor John Read, for a maximum of 3 years, following which all data will be deleted.

What if I been adversely affected by taking part?

It is not anticipated that you will have been adversely affected by taking part in the research, and all reasonable steps have been taken to minimise distress or harm of any kind. Nevertheless, it is possible that your participation – or its after-effects – may have been challenging, distressing or uncomfortable in some way. If you have been affected in any of those ways, you may find the following resources/services helpful in relation to obtaining information and support:

The NHS provides a list of useful helplines if you find yourself negatively affected in any way by this study. https://www.nhs.uk/mental-health/nhs-voluntary-charity-services/charity-and-voluntary-services/get-help-from-mental-health-helplines/

Mind – How can I help myself? This page includes information on how to support yourself when experiencing mental health problems. https://www.mind.org.uk/information-support/types-of-mental-health-problems/mental-health-problems-introduction/self-care/

Who can I contact if I have any questions/concerns?

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me.

Katie McLaren – Email: u2195532@uel.ac.uk

If you have any questions or concerns about how the research has been conducted,
please contact my research supervisor, Professor John Read. School of Psychology,
University of East London, Water Lane, London E15 4LZ,
Email: j.read2@uel.ac.uk

or

Chair of School Ethics Committee: Dr Trishna Patel, School of Psychology,
University of East London, Water Lane, London E15 4LZ.
(Email: t.patel@uel.ac.uk)

Thank you for taking part in my study.

Ethics Form Appendix D: Study Advertisement

Hello,

I am a clinical psychology student at the University of East London. As part of my dissertation, I am conducting research into the experiences that people have when attempting to share their experiences of childhood adversity to mental health professionals. Childhood adversity is the experience of stressful events that had, and may still have, an impact on your physical and/or psychological wellbeing (e.g., childhood abuse, neglect, poverty, and so on).

I am looking for participants who are between the ages of 18 and 40, have experienced childhood adversity, and have sought support from mental health services in the past 20 years. If you fit these criteria, I would appreciate if you could spare some time to take part in my study. This survey should take about 20 minutes to complete. If you wish to participate, please follow the link below:
[Insert the link of the survey]

Your participation would be much appreciated. If you wish to raise any concerns or questions, please do not hesitate to email me: u2195532@uel.ac.uk

Many thanks,

Katie McLaren – Trainee Clinical Psychologist

Ethics Form Appendix E: Researcher-Developed Questions to be Administered and Expanded ACE Questionnaire (Cronholm et al., 2015)

Number	Question	Possible answers:
1	Are you between the ages of 18 and 40?	Yes No
2	Please specify your age	Free response
3	Do you currently live in Great Britain?	Yes No
4	Our experiences in childhood can have an impact on our physical and psychological health in the future, even if these experiences happened a long time ago. Experiences of childhood adversity are very common. Childhood adversity can be described as the experience of stressful events that had/still have an impact on your physical and/or psychological wellbeing, such as childhood abuse, neglect, poverty, bullying, discrimination, and so on. Would you class yourself as having experienced childhood adversity?	Yes No I prefer not to say
5	Have you sought support from mental health services in the past 20 years?	Yes No

6	How do you describe yourself? If ‘I prefer to self-describe’ selected:	Male Female Non-binary I prefer to self-describe I prefer not to say Free response
7	What best describes your ethnic origin?	Drop down list of ethnicities: **Asian or Asian British** Indian Pakistani Bangladeshi Chinese Any other Asian background **Black, Black British, Caribbean, or African** Caribbean African Any other Black, Black British, or Caribbean background **Mixed or multiple ethnic groups** White and Black Caribbean White and Black African White and Asian Any other Mixed or multiple ethnic background **White** English, Welsh, Scottish, Northern Irish, or British Irish Irish Traveller Roma

		Any other White background **Other ethnic group** Arab Any other ethnic group I prefer not to say
8	What is the highest level of education you have completed?	Drop down list of education levels: No schooling completed Primary school Secondary school up to 16 years Higher or secondary or further education (A-levels, BTEC, etc.) College or university Post-graduate degree I prefer not to say
9	What is your current employment status?	Drop down list of employment status: Unemployed Part-time Full-time Other: free response
10	What is your marital status?	Drop down list of marital status: Single, never married Married or domestic partnership Widowed Divorced Separated
(Expanded ACE Questionnaire) The following questions will ask you about some common experiences of childhood adversity.		

11	While you were growing up how often did a parent, step-parent, or another adult living in your home swear at you, insult you, or put you down?	Never Once More than once
12.	While you were growing up how often did a parent, step-parent, or another adult living in your home act in a way that made you afraid that you would be physically hurt?	Never Once More than once
13.	While you were growing up did a parent, step-parent, or another adult living in your home push, grab, shove, or slap you?	Never Once More than once
14.	While you were growing up did a parent, step-parent, or another adult living in your home hit you so hard that you had marks or were injured?	Never Once More than once
15.	During the first 18 years of life, did an adult or older relative, family friend, or stranger who was at least five years older than yourself ever touch or fondle you in a sexual way or have you touch their body in a sexual way?	Yes No
	And/Or	
16.	Attempt to have or actually have any type of sexual intercourse, oral, anal or vaginal with you?	Yes No
17.	There was someone in your life who helped you feel important or special.	Never true Rarely true Sometimes true Often true Very often true
18.	Your family sometimes cut the size of meals or skipped meals because there was not enough money in the budget for food.	Never true Rarely true Sometimes true Often true Very often true
19.	How often, if ever, did you see or hear in your home a parent, step-parent, or another adult who was helping to raise you being slapped, kicked, punched, or beaten up?	Never Once A few times Many times
20.	How often, if ever, did you see or hear in your home a parent, step-parent, or another adult who was helping to raise you being hit or cut with an object, such as a stick, cane, bottle, club, knife or gun?	Never Once A few times Many times

21.	Did you live with anyone who was a problem drinker or alcoholic?	Yes No
22.	Did you live with anyone who used illegal street drugs or who abused prescription medications?	Yes No
23.	While you were growing up, did you live with anyone who was depressed or mentally ill?	Yes No
24.	Did you live with anyone who was suicidal?	Yes No
25.	Were your parents were ever separated or divorced? (added question in from original ACE, missed out by expanded ACE)	Yes No
26.	Did you live with anyone who served time or was sentenced to serve time in a prison, jail, or other correctional facility?	Yes No
27.	How often, if ever, did you see or hear someone being beaten up, stabbed, or shot in real life?	Never Once A few times Many times
28.	While you were growing up... How often did you feel that you were treated badly or unfairly because of your race or ethnicity?	Never true Rarely true Sometimes true Often true Very often true
29.	Did you feel safe in your neighbourhood?	None of the time Some of the time Most of the time All the time
30.	Did you feel people in your neighbourhood looked out for each other, stood up for each other, and could be trusted?	None of the time Some of the time Most of the time All the time
31.	How often were you bullied by a peer or classmate?	None of the time Some of the time Most of the time All the time
32.	Were you ever in foster care?	Yes No

33	Have you ever told mental health professionals about your experience of childhood adversity?	Yes No
	If answered yes to question 33:	
33.1.	What helped you to feel able to share your experience of childhood adversity?	Free response – please write as little or as much as you would like.
33.2.	What was helpful and/or unhelpful during the process of telling the mental health professional about your experience of childhood adversity?	Free response
33.3.	Were there any barriers to telling the mental health professional about your experience of childhood adversity?	Free response
33.4.	Was there anything that could have been done differently by the mental health professional to help you to share your experience of childhood adversity?	Free response
	(If answered no to question 33:	
34.	Did you want to tell mental health professionals about your experience of childhood adversity?	Yes No
	If no to question 34:	
34.1.	would you like to make any comments regarding this?)	Free response
34.2.	If yes to question 34:	
	What made you decide not to tell mental health professionals about your experience of childhood adversity?	Free response
34.3.		Free response

34.4.	Were there any barriers to telling the mental health professional about your experience of childhood adversity? Was there anything that could have been done differently by the mental health professional to help you to share your experience of childhood adversity?	Free response
35.	Did the mental health professional ask if you had experienced childhood adversity?	Yes No
	If yes to question 35:	
35.1.	How did you feel about being asked about childhood adversity?	Free response
35.2.	The mental health professional asked in a sensitive manner.	Strongly disagree to strongly agree
35.3.	How helpful was the mental health professional's response?	Not at all helpful to very helpful
35.4.	The mental health professional listened to and acknowledged what I was saying.	Strongly disagree to strongly agree
35.5.	I was satisfied with how the service responded to me when sharing my experience of childhood adversity.	Strongly disagree to strongly agree
	If no to question 14:	
35.6.	How did you feel when you were not asked about your experience of childhood adversity?	Free response
36.	I got the help that I needed from the mental health professional and the mental health service.	Strongly disagree to strongly agree
37.	If you would like to receive a written summary of the results following completion of the research, please provide your email address.	Free response
38.	If you would be happy for us to contact you for an online interview about your experience, please provide your email address.	Free response

Ethics Form Appendix F: Permission from External Organisations

The responses expressing permission from External Organisations have not been included to ensure confidentiality.

Ethics Form Appendix G: General Risk Assessment Form

UEL Risk Assessment Form

Name of Assessor:	**Katie McLaren**	**Date of Assessment:**	
Activity title:	**Exploring Barriers to Disclosure of Childhood Adversity to Mental Health Professionals**	**Location of activity:**	**Online**
Signed off by Manager: (Print Name)	**Professor John Read**	**Date and time: (if applicable)**	**March-July 2023**

Please describe the activity/event in as much detail as possible (include nature of activity, estimated number of participants, etc.).
If the activity to be assessed is part of a fieldtrip or event please add an overview of this below:

The study consists of data collection for a research project and dissertation. The data will be collected anonymously via an online questionnaire using Qualtrics. The approximate duration of the data collection will be 20 minutes.

Overview of FIELD TRIP or EVENT:

NA – research study

Guide to risk ratings:

a) Likelihood of Risk	b) Hazard Severity	c) Risk Rating (a x b = c)
1 = Low (Unlikely)	1 = Slight (Minor / less than 3 days off work)	1-2 = Minor (No further action required)
2 = Moderate (Quite likely)	2= Serious (Over 3 days off work)	3-4 = Medium (May require further control measures)
3 = High (Very likely or certain)	3 = Major (Over 7 days off work, specified injury or death)	6/9 = High (Further control measures essential)

Hazards attached to the activity

Hazards identified	Who is at risk?	Existing Controls	Likelihood	Severity	Residual Risk Rating (Likelihood x Severity)	Additional control measures required (if any)	Final risk rating

Potential psychological risk -questions in the survey may be potentially emotionally distressing.	Participants	Participants are informed that they can withdraw from the study at any time. Participants will be provided with links to supportive organisations should they experience emotional distress.	1	1	2		1

Appendix E: Ethics Acceptance Letter

University of East London

School of Psychology Ethics Committee

NOTICE OF ETHICS REVIEW DECISION LETTER

For research involving human participants
BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

Reviewer: Please complete sections in blue | **Student:** Please complete/read sections in orange

Details

Reviewer:	**Paula Corredor-Lopez**
Supervisor:	**John Read**
Student:	**Katie McLaren**
Course:	**Professional Doctorate in Clinical Psychology**
Title of proposed study:	Exploring Clients' Experiences of Disclosing Childhood Adversity to Mental Health Professional

Checklist

(Optional)

	YES	NO	N/A
Concerns regarding study aims (e.g., ethically/morally questionable, unsuitable topic area for level of study, etc.)	☐	☒	☐
Detailed account of participants, including inclusion and exclusion criteria	☒	☐	☐
Concerns regarding participants/target sample	☐	x☐	☐
Detailed account of recruitment strategy	☒	☐	☐

Concerns regarding recruitment strategy	☐	x☐	☐
All relevant study materials attached (e.g., freely available questionnaires, interview schedules, tests, etc.)	☒	☐	☐
Study materials (e.g., questionnaires, tests, etc.) are appropriate for target sample	x☐	☐	☐
Clear and detailed outline of data collection	☒	☐	☐
Data collection appropriate for target sample	x☐	☐	☐
If deception being used, rationale provided, and appropriate steps followed to communicate study aims at a later point	☐	☐	☒
If data collection is not anonymous, appropriate steps taken at later stages to ensure participant anonymity (e.g., data analysis, dissemination, etc.) – anonymisation, pseudonymisation	☐	☐	☒
Concerns regarding data storage (e.g., location, type of data, etc.)	☐	☒	☐
Concerns regarding data sharing (e.g., who will have access and how)	☐	☒	☐
Concerns regarding data retention (e.g., unspecified length of time, unclear why data will be retained/who will have access/where stored)	☐	☒	☐
If required, General Risk Assessment form attached	x☐	☐	☐
Any physical/psychological risks/burdens to participants have been sufficiently considered and appropriate attempts will be made to minimise	x☐	☐	☐
Any physical/psychological risks to the researcher have been sufficiently considered and appropriate attempts will be made to minimise	☒	☐	☐
If required, Country-Specific Risk Assessment form attached	☐	☐	☒
If required, a DBS or equivalent certificate number/information provided	☐	☐	☒
If required, permissions from recruiting organisations attached (e.g., school, charity organisation, etc.)	☒	☐	☐
All relevant information included in the participant information sheet (PIS)	☒	☐	☐
Information in the PIS is study specific	☒	☐	☐
Language used in the PIS is appropriate for the target audience	☒	☐	☐
All issues specific to the study are covered in the consent form	☒	☐	☐
Language used in the consent form is appropriate for the target audience	☒	☐	☐
All necessary information included in the participant debrief sheet	☒	☐	☐
Language used in the debrief sheet is appropriate for the target audience	☒	☐	☐
Study advertisement included	☒	☐	☐
Content of study advertisement is appropriate (e.g., researcher's personal contact details are not shared, appropriate language/visual material used, etc.)	☒	☐	☐

Decision options

APPROVED	Ethics approval for the above-named research study has been granted from the date of approval (see end of this notice), to the date it is submitted for assessment.
APPROVED - BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES	In this circumstance, the student must confirm with their supervisor that all minor amendments have been made **before** the research commences. Students are to do this by filling in the confirmation box at the end of this form once all amendments have been attended to and emailing a copy of this decision notice to the supervisor. The supervisor will then forward the student's confirmation to the School for its records. **Minor amendments guidance:** typically involve clarifying/amending information presented to participants (e.g., in the PIS, instructions), further detailing of how data will be securely handled/stored, and/or ensuring consistency in information presented across materials.
NOT APPROVED - MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED	In this circumstance, a revised ethics application **must** be submitted and approved **before** any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application. **Major amendments guidance:** typically insufficient information has been provided, insufficient consideration given to several key aspects, there are serious concerns regarding any aspect of the project, and/or serious concerns in the candidate's ability to ethically, safely and sensitively execute the study.

Decision on the above-named proposed research study

Please indicate the decision:	**APPROVED**

Minor amendments

Please clearly detail the amendments the student is required to make

Major amendments
Please clearly detail the amendments the student is required to make

Assessment of risk to researcher		
Has an adequate risk assessment been offered in the application form?	**YES** ☒	**NO** ☐
	If no, please request resubmission with an **adequate risk assessment.**	
If the proposed research could expose the researcher to any kind of emotional, physical or health and safety hazard, please rate the degree of risk:		
HIGH	Please **do not approve a high-risk** application. Travel to countries/provinces/areas deemed to be high risk should not be permitted and an application not be approved on this basis. If unsure, please refer to the Chair of Ethics.	☐
MEDIUM	Approve but include appropriate recommendations in the below box.	☐
LOW	Approve and if necessary, include any recommendations in the below box.	☒
Reviewer recommendations in relation to risk (if any):	**None. It was my first Ethics approval with no amendments in a couple of years now. Appreciated the amount of effort and attention to the task/accuracy involved in this submission**	

Reviewer’s signature

Reviewer: (Typed name to act as signature)	**Dr Paula Corredor Lopez**
Date:	**13/02/2023**

This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Ethics Committee

RESEARCHER PLEASE NOTE

For the researcher and participants involved in the above-named study to be covered by UEL’s Insurance, prior ethics approval from the School of Psychology (acting on behalf of the UEL Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

For a copy of UEL’s Personal Accident & Travel Insurance Policy, please see the Ethics Folder in the Psychology Noticeboard.

Confirmation of minor amendments

(Student to complete)

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data

Student name: (Typed name to act as signature)	Please type your full name
Student number:	Please type your student number
Date:	Click or tap to enter a date

Please submit a copy of this decision letter to your supervisor with this box completed if minor amendments to your ethics application are required

Appendix F: Ethics Amendment

School of Psychology Ethics Committee

REQUEST FOR AMENDMENT TO AN ETHICS APPLICATION

For BSc, MSc/MA and taught Professional Doctorate students

Please complete this form if you are requesting approval for proposed amendment(s) to an ethics application that has been approved by the School of Psychology

Note that approval must be given for significant change to research procedure that impact on ethical protocol. If you are not sure as to whether your proposed amendment warrants approval, consult your supervisor or contact Dr Trishna Patel (Chair of School Ethics Committee).

How to complete and submit the request

1	Complete the request form electronically.
2	Type your name in the 'student's signature' section (page 2).
3	When submitting this request form, ensure that all necessary documents are attached (see below).
4	Using your UEL email address, email the completed request form along with associated documents to Dr Trishna Patel: t.patel@uel.ac.uk
5	Your request form will be returned to you via your UEL email address with the reviewer's decision box completed. Keep a copy of the approval to submit with your dissertation.
6	Recruitment and data collection are **not** to commence until your proposed amendment has been approved.

Required documents

A copy of your previously approved ethics application with proposed amendment(s) added with track changes.	**YES** ☒

Copies of updated documents that may relate to your proposed amendment(s). For example, an updated recruitment notice, updated participant information sheet, updated consent form, etc.	**YES** ☒
A copy of the approval of your initial ethics application.	**YES** ☒

Details

Name of applicant:	**Katie McLaren**
Programme of study:	**Doctorate in Clinical Psychology**
Title of research:	**Exploring Clients' Experiences of Disclosing Childhood Adversity to Mental Health Professionals**
Name of supervisor:	**Professor John Read**

Proposed amendment(s)

Briefly outline the nature of your proposed amendment(s) and associated rationale(s) in the boxes below

Proposed amendment	**Rationale**
An amendment to the recruitment strategy to include contact with additional mental health organisations (e.g. XXXX) and social media mental health support groups that do not have a direct focus on childhood trauma/adversity, in addition to undergraduate and postgraduate psychology students.	It has been difficult to access the numbers required for the study – contacting mental health support groups and organisations may widen recruitment opportunities and allow participants with experiences of childhood adversity who aren't members of specific childhood adversity organisations to take part in the research.
Proposed amendment	Rationale for proposed amendment
Proposed amendment	Rationale for proposed amendment
Proposed amendment	Rationale for proposed amendment

Confirmation

Is your supervisor aware of your proposed amendment(s) and have they agreed to these changes?	**YES** ☒	**NO** ☐

Student’s signature

Student: (Typed name to act as signature)	**Katie McLaren**
Date:	**12/10/2023**

Reviewer’s decision

Amendment(s) approved:	**YES** ☒	**NO** ☐
Comments:	**Please ensure relevant permission is sought from social media mental health support groups. Please obtain written confirmation from organisations/universities willing to support with recruitment. Please do not advertise the study using any personal accounts.**	
Reviewer: (Typed name to act as signature)	**Trishna Patel**	
Date:	**12/10/2023**	

University of East London

School of Psychology Ethics Committee

REQUEST FOR TITLE CHANGE TO AN ETHICS APPLICATION

For BSc, MSc/MA and taught Professional Doctorate students

Please complete this form if you are requesting approval for a proposed title change to an ethics application that has been approved by the School of Psychology

By applying for a change of title request, you confirm that in doing so, the process by which you have collected your data/conducted your research has not changed or deviated from your original ethics approval. If either of these have changed, then you are required to complete an 'Ethics Application Amendment Form'.

How to complete and submit the request

1	Complete the request form electronically.
2	Type your name in the 'student's signature' section (page 2).
3	Using your UEL email address, email the completed request form along with associated documents to Dr Jérémy Lemoine (School Ethics Committee Member): j.lemoine@uel.ac.uk
4	Your request form will be returned to you via your UEL email address with the reviewer's decision box completed. Keep a copy of the approval to submit with your dissertation.

Required documents

A copy of the approval of your initial ethics application.	**YES** ☒

Details

Name of applicant:	**Katie McLaren**
Programme of study:	**Doctorate in Clinical Psychology**
Title of research:	**Exploring Clients' Experiences of Disclosing Childhood Adversity to Mental Health Professionals**
Name of supervisor:	**John Read**

Proposed title change

Briefly outline the nature of your proposed title change in the boxes below

Old title:	Exploring Clients' Experiences of Disclosing Childhood Adversity to Mental Health Professional
New title:	Exploring Clients' Experiences of Disclosing Childhood Adversity to Mental Health Professionals
Rationale:	The title was typed incorrectly on the ethics approval letter – a missing 's'

Confirmation

Is your supervisor aware of your proposed change of title and in agreement with it?	**YES** ☒	**NO** ☐

Does your change of title impact the process of how you collected your data/conducted your research?	**YES** ☐	**NO** ☒

Student’s signature

Student: (Typed name to act as signature)	**Katie McLaren**
Date:	**08/05/2024**

Reviewer’s decision

Title change approved:	**YES** ☒	**NO** ☐
Comments:	**There was a typo in the title. The title change will not impact the process of how the data are collected or how the research is conducted.**	
Reviewer: (Typed name to act as signature)	**Dr Jérémy Lemoine**	
Date:	**08/05/2024**	