"It's not just you and them in a closed room" - When therapy leads to reporting:

An IPA study exploring how adult survivors of childhood abuse experience mandatory reporting during psychotherapy.

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Declaration

I hereby certify that this material, which I now submit for assessment on the programme of study leading to the award of Doctor of Psychotherapy (DPsych) is entirely my own work, and that I have exercised reasonable care to ensure that the work is original and have conformed to the regulations on the use and declaration of Generative AI, and does not to the best of my knowledge breach any law of copyright, and has not been taken from the work of others save and to the extent that such work has been cited and acknowledged within the text of my work.

I hereby certify that no Generative Artificial Intelligence (Gen AI) tools have been used in the creation of the thesis.

Signed: Sharon Cunningham

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Dedication

To all of those who have experienced childhood abuse and found the courage to speak their truth.

I hope this work goes some way to strengthening your voices.

Acknowledgements

I am deeply grateful to the ten participants who volunteered to take part in this study; without their generosity, this research would not have been possible.

I am profoundly thankful to Dr Aisling McMahon and Dr Denise Proudfoot for their endless patience and endurance in supervising me during the completion of this study, despite the unending setbacks. Without their supervision, support, guidance, feedback, belief and encouragement, I would not have reached the finish line. Thank you both for sticking with me.

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Key Terms

The following group of terms are used interchangeably throughout this study;

- Counsellor, psychotherapist, therapist, psychologist, clinician and mental health professional providing psychotherapeutic therapy.
- Mandatory reporting, reporting, and mandated reporting.
- Child abuse, abuse, childhood abuse, child maltreatment.
- Abuser, perpetrator.
- Adult survivors of abuse, adult survivors.

Terms used in this study;

- Historical or retrospective child abuse refers to adults disclosing abuse they experienced as children. These terms are used interchangeably throughout the study.
- Health Service Executive – Irish Health Service.
- Intake in psychotherapy – Usually the first counselling session where the counselling contract, including the limits of confidentiality, is discussed and agreed upon between the therapist and the client.
- Tusla – The Child and Family Agency in Ireland, the government body responsible for Irish Child Protection Services

Abstract

Sharon Cunningham

"It's not just you and them in a closed room" – When therapy leads to reporting: An IPA study exploring how adult survivors of childhood abuse experience mandatory reporting during psychotherapy.

Many governments consider mandatory reporting of child abuse essential for protecting children by alerting authorities to risks. Mandated reporters, such as counsellors and psychotherapists, face legal obligations that complicate their therapeutic roles. In countries like Ireland, these laws also mandate the reporting of past abuse, presenting additional challenges for therapists and clients with histories of abuse. While some studies have examined the therapists' experiences with mandatory reporting, there is a minimal body of research exploring the experiences of psychotherapy clients. This study aims to bridge this gap by examining how adult survivors of child abuse experience mandatory reporting during psychotherapy. A sample of 10 participants (seven females and three males) was recruited through various means, including direct advertising and referrals from psychotherapy organisations and practitioners. Semi-structured interviews were conducted in-person or via Zoom to gather participants' accounts of their lived experiences. Interpretive phenomenological analysis was used to analyse the data. The research identified four key themes: First, *'Figuring Out Disclosure'* describes the significant decision-making processes participants underwent regarding the disclosure of their abuse experiences, before and during the early stages of therapy. Second, *'Living Through a Sudden Upheaval'* details the complex response experienced when the need for mandated reporting entered the therapeutic environment, and how this can intensify with time and trigger past traumas. Third, *'A Turning Point, Held by the Therapist'* explores how responses to mandatory reporting varied; some participants reported re-traumatisation, while others experienced transformation, with the therapist and therapeutic relationship playing crucial roles in these divergent experiences. Finally, *'Finding Agency within the Unbearable*', here participants articulated various challenges encountered throughout the reporting process and how these were overcome. The findings are discussed in relation to existing empirical and theoretical literature and knowledge, as well as their potential implications for policy, clinical psychotherapy practice and training. By privileging the experiences of the ten participants, the findings from this study bring a unique understanding of mandatory reporting, both for psychotherapy and other mandated professions.

Chapter One:

Introduction

"Child abuse casts a shadow the length of a lifetime."

Herbert Ward (n.d.)

Globally, it is estimated that one billion children aged between two and seventeen experience some form of physical, emotional, or sexual abuse and/or neglect each year (World Health Organisation, 2024) and that globally, one in five women and one in seven men report being sexually abused as a child (UNICEF, 2024). Despite the existence of global laws and conventions designed to protect the lives and rights of children (Conte, 2014) and an international focus on child protection (Alvarez, 2005), many children still face abuse and neglect. The effects of such experiences can be long-lasting, impacting not only the children but also their families, friends, and communities (Affi et al., 2018; Norman et al., 2012). Researchers have found that childhood abuse and neglect can have significant lifelong consequences for survivors, including physical health issues (Felitti et al., 1998), mental health disorders (Kaplow & Widom, 2007), addiction problems (Douglas et al., 2010), and relationship difficulties (Cicchetti & Toth, 2005). Adult survivors are more vulnerable to these challenges, which can persist throughout their lives (Gilbert et al., 2009; Mathews et al., 2017). Thus, survivors often require additional support. This support can come from informal sources, such as family and friends; community sources, including support groups and workers; or formal professional help, such as counsellors, psychotherapists, and psychologists. Professional support can help survivors navigate challenges and heal from the impacts of their childhood experiences.

Mandatory reporting of child abuse and neglect represents a critical component of the child protection legislation that several countries have adopted to mitigate children's risk of harm. This framework is designed to ensure that children who are victimised or at risk are identified and that appropriate support and protection services are activated (Dubowitz, 2017; Finkelhor, 1999; Mathews et al., 2021). In jurisdictions where mandatory reporting laws have been implemented, certain professionals—typically those engaged in child and family services—are legally obligated to report any suspicions or knowledge of abuse. Additionally, some countries have expanded their mandatory reporting statutes to encompass historical or retrospective abuse, characterised as childhood abuse and neglect, disclosed by adult survivors (DeMause, 1998). This expansion acknowledges the significance of past abuse and its implications for current safeguarding practices.

Mandatory reporting laws present a considerable challenge for psychotherapy professionals, as practitioners must navigate the delicate balance between maintaining a secure and confidential therapeutic environment for their clients and fulfilling their legal and ethical obligations. These laws can also create significant barriers and obstacles to survivors' access to therapy and their healing processes (Pellegrini et al., 2023).

Background Information

This study arose from the researcher's professional experience as a psychologist in a rehabilitation centre serving marginalised groups. She also worked as the designated liaison officer for the organisation's child and adult safeguarding team. This dual role sparked her interest in safeguarding, particularly reporting. This focus became more prevalent in December 2017 after the implementation of the Mandatory Reporting for Child Abuse law in Ireland.

Additionally, the researcher maintains a private practice as a counselling psychologist, providing psychotherapy and counselling psychology to a diverse range of clients, many of whom have traumatic backgrounds. Throughout her career, the researcher has reported a substantial number of child abuse cases. Most concerned retrospective childhood abuse. As a mandated reporter, she found these experiences challenging and demanding. The reporting process felt like a tremendous responsibility, and there was pressure to get it right, as the consequences were so high for the clients, their lives, and their families. Her overall experiences with clients have been positive; no client has left therapy due to the reporting process. However, some clients did not return after the first session, in which reporting was discussed. The personal and professional challenges of balancing the therapeutic relationship with the mandatory reporting requirements led the researcher to ask, "What is it like sitting in the client's chair?" and "What is mandatory reporting like for my clients?". These reflections prompted her on a journey into the world of mandatory reporting, thus inspiring this research.

It is important to note that the researcher has no personal experience of childhood abuse or any form of mandatory reporting during therapy as a client.

Rationale for the Study

Mandatory reporting of childhood abuse and neglect is one of the mechanisms used to protect vulnerable children from harm. Since its introduction in the United States in the 1970s (Krugman & Korbin, 2012), it has received considerable attention from researchers. Most researchers have explored whether mandatory reporting is effective for preventing child abuse (Mathews & Bross, 2015), while others have examined the impact of these laws on reporting statistics (Ainsworth, 2002; Gilbert et al., 2009). Over the past few decades, there has been a new

empirical focus on the emotions, attitudes, and barriers experienced by different mandated reporter professions, including teachers (Goldman & Grimbeek, 2015; Kenny, 2001; Walsh et al., 2012), nurses (Bragança-Souza et al., 2024; Davidov et al., 2012; Fraser et al., 2010; Freed & Drake, 1999), doctors (Al Eissa & Almuneef, 2010), addiction and school counsellors (Easton, 2013; Hardy et al., 2023), psychologists (Cavett, 2003; Duncan et al., 2012; Pellegrini et al., 2022), and psychotherapists (Anderson et al., 1993; Borkosky & Smith, 2015; Steinberg et al., 1997). Among the studies exploring the attitudes of psychologists, counsellors, and psychotherapists, the perceived impact of mandated reporting on the therapy client, the therapeutic relationship, and the therapeutic process has been examined. Although this body of research is invaluable to clinicians for ensuring evidence-based practice and for shedding light on the impact of the mandated process on a private, confidential experience, only 15 studies have been published. Many of these studies are outdated or were conducted in the U.S. or Australia, limiting their generalisability across different cultural and legal contexts. Only one recent published study was conducted with Irish psychologists (Pellegrini et al., 2023).

Studies that privilege the voices and experiences of psychotherapy clients and address mandated reporting in psychotherapy are extremely rare. Only three studies were found during the extensive search strategy of the current study. Of these three, one, a Scottish qualitative study, explored the experiences of survivors and therapists working with this client group about talking therapy services for adult survivors of abuse; both groups spoke about the impact of mandated reporting on their experiences of therapy (Chouliara et al. 2011). The other two focused solely on the experiences of the psychotherapy client when reporting entered therapy. In one, an unpublished mixed-methods Doctorate study (Rokop, 2003), the participants were psychotherapy clients who disclosed during therapy that they had perpetrated child abuse. The study focused on

their experience of having their perpetrated abuse reported. In the second, a published, qualitative study, Kelleher et al. (2012) explored the experiences of mandated reporting in therapy for adults attending therapy in a residential setting. Participants were, in all but one case, both survivors of childhood abuse and also perpetrators of child abuse. These studies are important because they acknowledge the psychotherapy client's experiences as distinct and unique and also form the basis for understanding these experiences. However, no studies (published or unpublished) to date were found that had focused solely on the experiences of the adult survivors of childhood abuse. The purpose of this study is to address this important gap in the literature by examining the experiences of adult survivors of childhood abuse as they navigate the process of mandatory reporting during psychotherapy. By gaining insight into clients' journeys and amplifying their voices, the findings will contribute to professional knowledge and practices, enhance clients' experiences of the reporting process, which will help protect children who are vulnerable to abuse in the future, and enable clinicians to maintain the delicate balance between confidentiality and legal responsibilities.

Aims and Objectives of the Study

The aim of this study is to explore how adult survivors of childhood abuse experience the mandatory reporting of abuse during psychotherapy. This study has four objectives.

- To illuminate the impact, if any, of mandatory reporting on clients' experience of the therapeutic relationship.

- To discover the influence, if any, of the mandatory reporting process on clients' experience of the therapeutic process and therapeutic outcomes.

- To uncover the perceived effects, if any, of mandatory reporting on clients' experiences of the psychotherapist.

- To explore how clients make sense of the experience and perceived impact of mandatory reporting in their broader life contexts, such as well-being, relationships, and coping.

Methodology

To align with this study's aim of examining individual experiences related to mandatory reporting of childhood abuse during psychotherapy, interpretive phenomenological analysis (IPA) (Smith et al., 2022) was selected as the methodological approach. This method is effective for exploring how individuals make sense of their lived experiences. It has an idiographic approach, exploring and offering insights into how individuals experience specific phenomena in specific situations. In this study, the specific phenomenon examined was mandatory reporting, specifically within the context of psychotherapy. Data was collected through semi-structured interviews. Ten adults who had experienced childhood abuse were interviewed about their experiences of mandatory reporting during psychotherapy, allowing them to share their experiences. The data from the interviews were then analysed using the rigorous and detailed analytical process of IPA, including the researcher's own interpretations, which added to the rich and in-depth accounts.

Thesis Outline

Chapter One begins with an introduction to the study, the study's background and rationale. The aims and objectives are discussed, followed by a brief overview of the methodology, and concluded with an outline of the thesis.

Chapter Two is a critical review of the current literature on mandatory reporting and psychotherapy. It situates mandatory reporting as a form of child protection, internationally and in the Irish context. The effectiveness of mandatory reporting is considered along with a critical examination of psychotherapy. The minimal literature available on the intersection of psychotherapy and mandatory reporting is critically considered, along with the few studies that consider the adult survivors' experiences. It concludes with the researcher's reflective comments.

In Chapter Three, the aim and objectives of the study are presented, as well as the study design and methodology, and the rationale for choosing IPA as the study's methodological approach. The theoretical and philosophical underpinnings of IPA are considered. The study design, including the recruitment strategy, data collection, data analysis, and ethical considerations, which were especially important in the current study due to the potential vulnerabilities of the participants, are then described.

The findings are presented in Chapter Four. These are presented in table form and comprise four group experiential themes (GETs) and 12 sub-themes. The GETs are *'Figuring Out Disclosure', 'Living Through a Sudden Upheaval', 'A Turning Point, Held by the Therapist'* and *'Finding Agency in the Unbearable'.* These GETs highlight both the convergence and the divergence of participants' lived experiences. The findings are supported by direct quotations from the data, demonstrating that they are rooted in participants' lived experiences.

In Chapter Five, the four GETs are contextualised within existing literature to enhance our understanding of adult survivors and their experiences with mandatory reporting during therapy. The findings will also be theoretically conceptualised using Self-Determination theory (Ryan & Deci, 2017) and trauma-informed care (Herman, 1992). This analysis aims to inform psychotherapy practices for this population.

Chapter Six discusses the study's implications for psychotherapy practice, training, research, and policy. It outlines conclusions and recommendations for clinical practice and the role of mandated reporters. The study's strengths and weaknesses are evaluated, along with its quality and validity, using Yardley's (2000) principles as advised by Smith et al. (2022).

Chapter Two

Literature Review

"The true character of a society is revealed in how it treats its children"

(Mandela, 1997)

Introduction

One in four of the world's children experience abuse and neglect during their lifetime (Brown et al., 2023). It is a sobering truth that in today's world, many children still suffer abuse, often in silence and without support. Despite significant societal progress, the protection of children remains an ongoing global challenge. One of the most significant global advances in child protection was the establishment of the United Nations Convention on the Rights of the Child (UNCRC) in 1989. This convention represented a turning point in how global societies viewed children and their rights, serving as a mechanism to ensure that children's rights are recognised and protected worldwide. Ireland, along with every country in the world except one, has adopted this convention. The Irish Government signed the convention in 1990 and subsequently ratified it into law in 1992 (UN Treaty Collection, n.d.). This sequence of actions demonstrates Ireland's commitment to adhering to the principles outlined in the convention and its willingness to engage with international legal frameworks. The convention includes provisions for protecting children from harm and abuse, obligating countries to implement laws and protections to prevent such adversity. Many nations have adopted mandatory reporting laws regarding child abuse and neglect as a way to safeguard children and bring incidents of abuse and abusers to light, helping to ensure the protection and care of victims (Finkelhor, 2009; Mathews, 2012; McTavish et al., 2017). In Ireland, this legal requirement is outlined in the

Children First Act 2015, which mandates that individuals who work with children, families, and adult survivors must notify the appropriate authorities of confirmed or suspected cases of child abuse (Irish Statute Book 2015). These professionals include counsellors, psychotherapists, and psychologists (Department of Children and Youth Affairs, 2017).

Many therapists work with both children and adults who have experienced childhood abuse. These early, traumatic experiences can leave deep and lasting impacts on mental, emotional, developmental, relational and physical well-being, which can shape the course of children's lives, and these impacts can impact survivors throughout their lifetimes (Classen et al., 2001; Lang et al., 2020; Mathews et al., 2017; Sanderson, 2006; Toth & Manly, 2019). When adult survivors disclose past abuse during therapy, therapists in countries like Ireland, where reporting is mandated, must inform child protective services (Tusla). This legal obligation poses challenges for both therapists and clients, yet research on this issue remains scarce.

This literature review aims to critically evaluate the literature on mandatory reporting of childhood abuse, focusing on the Irish context and research related to psychotherapy. It will outline the search strategy, define child abuse and reporting requirements, and discuss mandatory reporting as a child protection measure. Key aspects of psychotherapy will be reviewed, alongside the role of psychotherapy in supporting adult survivors. Finally, the limited and often outdated empirical research on mandated reporting and psychotherapy will be critically examined, with an emphasis on clients' lived experiences of mandatory reporting in this context.

Search Strategy

A comprehensive review of selected electronic databases (PubMed, Psych Info, ScienceDirect, Academic Search Complete, and CIMHL) was conducted using the following

search terms: child abuse (including childhood abuse, child maltreatment, child sexual abuse, historical abuse); mandatory reporting (including mandated reporting; mandated persons); therapy (including psychotherapy; counselling; counseling); experience (including lived experience; perceptions; beliefs; attitudes); clients (including patients; service users) and therapists (including counsellors; counselors; psychologists; psychotherapists). Each database was searched with just the terms mandatory reporting (and all its alternatives) and then searching with mandatory reporting (and the alternatives) as the stable search, with each of the terms (and all the alternative spellings) added separately, i.e., mandated reporting and child abuse, mandated reporting and therapy, and so on. An extensive timeframe of 1980 to 2025 was chosen, as this aligns with the first US child protection laws (1974), which led to an abundance of empirical studies from the late 1970s through to the 2000s, investigating the effectiveness of child protection measures and detection. The initial search returned over 3,000 hits; duplicates were removed, along with studies deemed irrelevant. These decisions were based on the relevance of the title or abstract. This narrowed the search to just over 550 articles, all of which were reviewed in detail for their relevance to the study. A thorough review of qualitative and quantitative studies was conducted, focusing on those relevant to the current study. All papers that considered mandatory reporting and psychotherapy, or the therapeutic relationship, or experiences of psychotherapists, counsellors, or mental health professionals offering therapeutic services or their clients, were included. Due to the limited number of studies on mandatory reporting in psychotherapy (15), all available studies have been included, which includes much outdated research. The reference lists of key articles were reviewed for additional relevant papers. A search on Google Scholar using the specified terms above identified further literature. Recent Irish government reports on child abuse and its reporting were also considered.

Development of Mandatory Reporting Laws

The evolution of reporting legislation as a mechanism for safeguarding children will initially be examined within a global framework, before turning to a detailed analysis of The implementation of such laws within the Irish context.

Historical Background

In 1997, Nelson Mandela stated that the way a society treats its children reveals its true character (see Chapter's opening quote) (Mandela, 1997). Although this may be the case in the 21st century, children's welfare and protection have not always been a priority. The maltreatment of children has a lengthy and sombre past. The earliest recorded cases date back to ancient civilisations, where it was acceptable to sacrifice unwanted or rejected children to appease the gods (Breiner, 2013). Children were often sexually abused and used in prostitution. By the thirteenth century in European society, physical beatings were considered to be in the child's best interest, necessary for discipline, and a desirable way to socialise children (Hart, 1991). Social norms, cultural practices, and governing organisations influenced how children were treated. For instance, Postman (1982) asserted that the Renaissance led to a new perspective on childhood, particularly within upper-class societies. Children began to spend more time engaged in educational programs and were encouraged to participate in activities separate from adults, while socialising with their peers. This signified a shift in societal perceptions, where children were seen as being distinct from adults, "like moulds of clay to be moulded" (Postman, 1982, p. 259). This led to a global shift in which children were recognised as a distinct, vulnerable group requiring certain rights, protection, and care.

Two historical cases have significantly shaped today's child protection laws, policies, and procedures. The first of these was the lesser-known case of Mary Ellen Wilson in the USA. in 1987. Mary Ellen was a 10-year-old girl living with a foster family in New York. She was subjected to extreme neglect and both physical and emotional abuse at the hands of her foster mother. Neighbours raised concerns to a local missionary worker, who, with the help of a local businessman, ensured that Mary Ellen was removed from her foster family for her own safety and at trial, her foster mother received a custodial sentence for her actions. The first of its kind in the U.S. (Watkins, 1990). This case led to the establishment of the first-ever organisation dedicated to protecting children from abuse: the New York Society for the Prevention of Cruelty to Children (NYSPCC) in 1875. This case brought the issue of child abuse to the public's attention. It also highlighted abuse within the family, something that was considered, up until this point, a personal matter that did not concern the authorities or require outside interventions (Jalongo, 2006).

The second case originated in Colorado, USA, a mere 62 years ago. Dr Kempe and colleagues wished to explain patterns of injury they saw in hospital emergency rooms, where children presented with injuries, severe fractures, and convulsions, which were inconsistent with their parents' and caregivers' explanations. They undertook a study and discovered that such children had sustained significant injuries and even death (Kerns et al., 2023). X-rays were used as the objective evidence that abuse had taken place. The findings from this study became known as 'the Battered-Child Syndrome' (Krugman & Korbin, 2012). Dr Kempe argued that the medical profession should take responsibility for what they saw in their patients to prevent further abuse (Kempe et al., 1962). Within five years of the publication of 'the Battered-Child Syndrome', every state in the U.S had some form of law requiring the reporting of child abuse

and neglect to a public agency. The Mary Ellen case, the identification of 'the Battered Child Syndrome', and the subsequent requirement for reporting cases of child maltreatment are the foundations of child protection services, laws, structures, policies, and procedures in place today.

However, perhaps the most important step towards the global protection of children was the establishment of the UNCRC in 1989. It has been ratified by every country in the world except the USA, establishing it as the most ratified human rights treaty in world history. There are four main principles within the Convention, namely non-discrimination; devotion to the best interests of the child; the right to life, survival and development; and respect for the views of the child. Under the principle of the right to life, survival and development is Article 19, which offers children protection from abuse and neglect. This article requires all countries to take appropriate action to protect children, including legal, administrative, educational and social measures, ensuring that legal protections for children against harm and abuse (United Nations, 1989, Article 19; Pais, 2010). Many countries have since implemented mandatory reporting of child abuse and neglect as a means of exposing abuse and abusers and ensuring the protection and care of victims (McTavish et al., 2017).

Global Legislative Frameworks

Early legislative frameworks for mandatory reporting laws emerged in response to the recognition of child abuse as a significant societal issue, where the aim was to establish systematic intervention mechanisms for children at risk. The United States, Canada, and Australia are often cited as leading nations in the development of mandatory reporting laws. These countries were the first nations to adopt such legislation, but have also undergone significant advancements in their reporting frameworks over time. Their experience provides

valuable insights into the evolution and effectiveness of mandatory reporting legislation (Ainsworth, 2002). For example, in the US, the Child Abuse Prevention and Treatment Act (CAPTA) of 1974 established the first federal framework for reporting child abuse and neglect (Child Abuse Prevention and Treatment Act, 1974). CAPTA required states to adopt mandatory reporting statutes as a condition for receiving federal funding, leading to widespread legislative implementation across the country (Liu & Vaughn, 2019).

The evolution of legal frameworks in Canada and Australia can be characterised as predominantly bottom-up rather than top-down, as in the US. In both nations, the initial enactment of legislation took place in specific jurisdictions, namely Ontario in Canada and South Australia in Australia (McCormick, 2018; Tonmyr et al., 2018). These foundational statutes were revised to address specific local needs and circumstances, leading to their adoption by additional territories. Today, all jurisdictions in both countries have mandatory reporting laws, each with their own unique framework (Mathews & Kenny, 2008; MacCormick, 2018; Tonmyr et al., 2018). Similar mandatory reporting legal systems have been established in many other global countries, such as South Africa, Japan, India, and numerous European nations, each influenced by distinct legal and cultural considerations (Bunting et al., 2010; Mathews & Kenny, 2008). In their 2008 review of mandatory reporting laws and their development, Mathews and Kenny compared the mandatory reporting legislation in Canada, the US and Australia. They asserted that all mandatory reporting laws have common elements, which include (1) details of the persons required to make the reports (mandated persons), (2) the level of knowledge, suspicion or belief the person must have before the duty to report is activated, this level is commonly described as “reasonable” as opposed to absolute (Mathews & Kenny, 2008, p.52), (3) the types of abuse and neglect that require reporting, (4) the level of abuse, often termed the ‘threshold of

abuse', which can include current and/or historic abuse and/or the potential for future harm and finally (5) the penalties for non-reporting. Despite these established common features of mandatory reporting laws, there are considerable individual, country-specific variations that add to and reflect the complexity of the global legislative process regarding mandatory reporting.

It is also important to note that certain countries have chosen not to implement mandatory reporting laws, instead adopting voluntary reporting systems with policy-based child protection measures. One of the main reasons cited for such decisions is the potential risk of including innocent cases in the over-reporting that accompanies such a protection mechanism, which can adversely affect the interests of children the system is designed to protect (Schwab-Reese et al., 2023). Such nations include Germany, the United Kingdom, New Zealand, the Netherlands and China (Mathews, 2014).

Significant changes have been made to the initial reporting laws, particularly in the U.S., Australia and Canada, which have influenced the drafting of more recent laws in nations just now adopting mandated reporting. One important change is the type of abuse requiring a mandated report to be made; the early laws predominantly focused on observable instances of current or recent abuse, often neglecting certain types of abuse and historical cases due to challenges related to evidence and the psychological complexities of delayed disclosures. This has expanded over time, and less obvious types of abuse, such as emotional abuse or neglect, are now widely reportable (Alaggia, 2004; Bekink, 2021; Goldman & Grimbeek, 2015). Another significant change concerns the professions mandated to report; early laws primarily targeted a limited number of professional groups who were positioned to identify signs of maltreatment, such as educators, healthcare providers, and social workers (Ainsworth, 2002). Over time, and influenced by the scope of local reporting statutes—whether narrow or broad—there has been an

expansion in the definition of professional groups designated as mandated reporters. Notably, in 18 states across the United States, there exist extensive or broad reporting laws, referred to as universal reporting laws, which classify all adults as mandated reporters for incidents of child abuse and neglect; similarly, most provinces in Canada have adopted a similar 'universal' approach. This broad framework signifies a proactive approach to safeguarding children and underscores the shared societal responsibility in identifying and reporting potential abuse and neglect (National Clearinghouse on Child Abuse and Neglect, 2019; Tonmyr et al., 2018). Whereas other states in the United States, along with nations such as Saudi Arabia, have adopted a more narrow, constrained framework regarding mandated reporting obligations, limiting this responsibility to a select group of professions, sometimes encompassing as few as four, reflecting a significant contrast in policy approaches (Afifi et al., 2018; National Clearinghouse on Child Abuse and Neglect, 2019). In Ireland, 18 different professional roles are mandated (Department of Children and Youth Affairs, 2017).

In a comparison of mandated reporting laws and their development, Mathews (2012) highlighted that early legislative initiatives frequently lacked clarity regarding the scope of reporting obligations. For example, the level of harm necessary for a mandated report to be activated which resulted in inconsistent implementation across jurisdictions. Terms such as "serious harm" and "threshold" have now been replaced with more specific definitions of what constitutes harm (Kalichman, 1999). The final area of significant change is around the nature of the evidence needed to make a report. Initially, as mentioned above, the laws were focused on objective, identifiable evidence; however, today, many countries have broadened this requirement to include reporting requirements where the mandated person has a belief or suspicion of child abuse. Mandated reports can be based solely on a suspicion or belief, while

others require more substantial evidence (Stoltenborgh et al., 2011; Walters, 1995). Additionally, certain countries only require reports to be made about children deemed to be at risk, while others, including Ireland, extend the reporting requirements to adult survivors or historical/retrospective abuse (Burbridge-Jones, 2018).

Mandatory reporting laws present a complex landscape that defies simplistic summarisation and comparison on a global scale. This complexity arises from the diverse local, social, cultural, legal, and political influences that shape these laws in different jurisdictions. Despite these inherent differences, it is essential to recognise the common underlying principles and shared objectives that inform mandatory reporting frameworks worldwide.

Irish Legislation

In 1999, the Irish Health Service Executive (HSE) published 'Children First: National Guidance for the Protection and Welfare of Children', marking the country's first official child protection policy and reporting procedures. It provided national guidance for professionals and organisations on keeping children safe, recognising harm and abuse, and reporting concerns. However, it did not include any form of mandated reporting. The legal framework for mandatory reporting is governed by the Children First Act 2015, which was enacted in November 2015 and came into full effect in December 2017. This Act, broadly based on the 'Children First' guidance, places a statutory obligation on certain professionals, including counsellors and psychotherapists, to report reasonable concerns of child abuse to Tusla, which is the State Agency in Ireland with legal responsibility for the welfare, protection and safeguarding of children (Children First Act, 2015; Hanly 2020).

The Act describes four types of reportable abuse: neglect, emotional, physical, and sexual abuse (see Children First Guidelines (Department of Children and Youth Affairs, 2017) for definitions. It also defines mandated reporting as the process by which the 'mandated person' must report "any knowledge, belief, or reasonable suspicions that a child has been harmed, is being harmed, or is at risk of being harmed " (Department of Children and Youth Affairs, 2017, p.19) to Tusla. Harm is defined as "assault, ill-treatment, neglect of the child in a manner that seriously affects or is likely to seriously affect the child's health, development or welfare, or any form of sexual abuse" (Department of Children and Youth Affairs, 2017, p. 25). 'Reasonable suspicions' do not require absolute certainty or concrete evidence. Instead, they are based on credible information or observations that would lead a reasonable professional to suspect abuse or neglect. The introduction of the Children First Act 2015, with the legal responsibility placed on 'mandated persons' and its broad focus on child protection, arguably reflects Ireland's commitment to strengthening child protection systems and aligning with international best practices (Department of Children, Disability and Equality, 2017; Hanly, 2020). However, this is an ever-changing landscape that has faced significant changes. The next section will consider some of these changes.

A Significant Challenge to the Irish Law

Since its inception in December 2017, the Irish mandatory reporting law has faced significant challenges in the Irish courts, most notably in McGrath v Health Service Executive (2023) (HSE), which focused on the reporting requirements for historic or retrospective abuse. The interpretation and implementation of reporting guidelines issued by the HSE (the Irish health system) were at the centre of the dispute, particularly concerning disclosures of historic child

abuse made by adults in therapeutic settings. The HSE's Child Protection and Welfare Policy (Health Service Executive, 2019) advised that any disclosure of abuse, whether current or retrospective, should be reported to Tusla if there were reasonable grounds for concern. The historical aspect of this policy was based on an interpretation of the threshold of abuse from the Child First Act 2015, which includes the wording, "if a child has been harmed, is being harmed …" (Department of Children and Youth Affairs, 2017, p. 7). The HSE's policy interpreted "has been harmed" as including adults who disclosed that they had been harmed as children. The rationale behind this was that such disclosures might indicate a broader pattern of risk, possibly involving other children who could still be in danger. In response, the National Counselling Service (NCS), a government-funded specialist service providing counselling to survivors of childhood abuse, along with many other organisations, raised concerns about this interpretation and its impact on the mandatory reporting of retrospective abuse. They argued that requiring counsellors to report adult disclosures of past abuse might discourage individuals from seeking help (Mooney & Daly, 2024). According to the NCS, this could paradoxically result in a reduction in the reporting of childhood abuse, as fewer adults might come forward to disclose their experiences in counselling environments perceived as unsafe or lacking confidentiality, and therefore fewer people in general might not disclose childhood abuse (O'Riordan, 2022).

This disagreement eventually led to a formal legal challenge by Tom McGrath (Director of Counselling at the NCS) on behalf of the NCS against the HSE, culminating in a 2022 court case. The case was found in favour of the HSE. That is, the High Court determined that Section 14(1)(a) of the Children First Act (2015) imposed a statutory obligation on mandated persons to notify Tusla when an adult disclosed childhood abuse, provided the reported harm met the threshold outlined in Section 2 of the Act (see section *Irish Legislation* above). This also

included circumstances where the alleged perpetrator was deceased, as the court stated that it was Tusla's responsibility to gather evidence of abuse and determine risk. The Court clarified that such a notification did not require the consent of the individual making the disclosure. Instead, it was incumbent upon the mandated professional to inform the individual of their legal reporting responsibilities, including the constraints this placed on professional confidentiality within the therapeutic context (Allen & Moran, 2024).

This ruling was appealed and overturned in 2024. The Court of Appeals judgment stated that "as a matter of ordinary grammar, the 'child' referred to section 14(1) of the 2015 Act cannot be interpreted to include an adult who suffered harm as a child" (Allen & Moran, 2024, p. 1). This means that an adult disclosure about past abuse no longer, in and of itself, triggers a statutory reporting obligation unless they indicate an identifiable ongoing risk to children. The Court emphasised that expanding reporting duties to include all retrospective disclosures would represent a significant policy shift and require explicit legislative intent. This judgment represents a pivotal moment for adult survivors of childhood abuse, along with mandated reporters, especially those providing psychotherapeutic services. For many years (prior to mandated reporting), practitioners had interpreted child protection policy as requiring them to report retrospective childhood abuse only if the name of the perpetrator was known, but since the 2022 ruling, all disclosures, regardless of known details and status of the abuser – alive or dead, required a mandated report to be made to Tusla. The Court's clarification in 2024 reorients this practice, emphasising the assessment of current risk above the reporting of all historic disclosures by default. The ruling also raises broader ethical and operational considerations for services engaging with survivors of childhood abuse. It highlights the importance of balancing the need to safeguard children with the necessity of maintaining trust in therapeutic relationships.

In summary, the historical evolution of mandatory reporting laws, both globally and in Ireland, underscores the complexities of creating effective legal frameworks for child protection. While early initiatives addressed immediate risks, they revealed significant gaps in managing historical disclosures, prompting the need for ongoing legislative revisions that account for legal obligations, ethical considerations, and survivors' needs (Bekink, 2021; Goldman & Grimbeek, 2015; Kelleher et al., 2012).

As these significant changes to the Irish mandatory reporting laws happened during the data collection stage of this study, and participants were subjected to different versions of the law, a brief summary of the chronology of these changes is below;

- December 2017 – Mandatory reporting laws come into effect.
- October 2022 – High Court Ruling – Amendment 1 – mandatory reporting of all historic cases, regardless of ongoing risk or abuser status.
- December 2023 – Court of Appeal Ruling – Amendment 2 – no need to report historic abuse unless there is a current risk to children (if the abuser is deceased, there is no risk)

The changes to Irish legislation during the course of this study have been significant and may have impacted the study; some implications considered included heightened public awareness, which may have either encouraged or discouraged participation. Survivors in therapy at the time of the changes would have experienced these changes first-hand, for example, the change that required all historical abuse to be reported, when this was not necessary in the past. Such a dramatic change could have prompted extreme personal experiences that might have led survivors to volunteer for the study, as they saw it as a way to have their voices heard. Finally, the increased focus on mandated reporting may have led therapists to feel discouraged about

discussing potential participation in the study with their clients, perhaps out of fear of further damaging the therapeutic relationship.

Having considered the development of mandatory reporting laws and the subsequent changes faced globally and in Ireland, focus will now shift to consider the ongoing debate around reporting and its effectiveness as a child protection measure.

Mandatory Reporting as a Form of Child Protection - An Ongoing Debate

The international statistics on child abuse are concerning and highlight the need for robust reporting measures, procedures, and systems, as well as government agencies equipped to receive and investigate allegations of abuse and neglect (Alaggia, 2004). The primary goal of mandatory reporting is to detect abuse and provide necessary services and interventions for victims (Morton & Oravecz, 2009). However, there is an ongoing debate about the efficacy of mandatory reporting in achieving this goal. How effective is it at uncovering abuse and thus reducing rates of child abuse and neglect? One key measure used to assess the effectiveness of mandatory reporting of child abuse is substantiation; that is, the number of child abuse reports made which, upon investigation, prove that child abuse has taken place. Since the introduction of mandatory reporting in the United States in the 1970s, extensive research has been conducted on substantiation rates both in the US and many other nations, which suggests varying rates of substantiation (Bright et al., 2022; deHaan et al., 2019; Dubowitz, 2017; Finkelhor et al., 2010; Gilbert et al., 2009; Scurich, 2024; Mathews & Kenny, 2008). Krase & DeLong-Hamilton (2015) conducted a quantitative research study using reported abuse cases for 2010 from the National Child Abuse and Neglect Data Centre in the US. They found that 26% of all child protection

service reports of abuse were upheld, indicating that, following investigation, the child was determined to have suffered abuse, with the remaining 74% being unsubstantiated (Krase & DeLong-Hamilton, 2015). The current national substantiation rate in the U.S. ranges from 22% to 30% of reported cases of abuse (Scurich, 2024). However, there is considerable variation across countries; for example, in 2022-23, Australia reported a substantiation rate of 44% (Australian Institute of Health and Welfare, 2024). Considering these statistics at face value, it would appear that Australia's reporting laws are uncovering more cases of child abuse than the U.S. However, this is not where the variation lies. In reality, it is in the different approaches each country has taken concerning the definition of abuse, reporting requirements, and how they investigate and substantiate cases, which makes it challenging to evaluate the extent to which mandated reporting uncovers childhood abuse. In Ireland, Tusla does not publish substantiation rates. However, it does publish the number of reports that, following preliminary screening (where reports are screened out if there is not enough information), are sent for further assessment or investigation. In 2024, Tusla reported that 28% of all the child protection reports received were forwarded for further assessment. Suggesting that 72% of referrals received were closed following the preliminary screening by social workers (Tusla – Child and Family Agency, 2025).

In 2022, Tusla introduced the Child Abuse Substantiation Procedure (CASP). This procedure aims to provide a consistent standard of child protection practice for assessments that social workers carry out to determine whether child abuse has occurred. Establishing this procedure has been a crucial step towards ensuring transparency and addressing nationwide inconsistencies (Mooney, 2021). The CASP enables survivors, alleged perpetrators, and professionals involved in mandatory reporting to understand the process better. Furthermore, it

provides a benchmark by which Tusla's ability to address allegations can be measured and reviewed. In 2024, the Tusla CASP was upgraded to Version 2 (see Tulsa.ie/CASP). This version is intended to enhance transparency, with both online and paper leaflets outlining all steps from reporting to investigation. It also addresses the unique needs of adults, children, and adolescents making disclosures.

Another area of concern regarding mandatory reporting is the effectiveness and timeliness of child protection services' assessment processes for identifying children at risk. Cocozza et al. (2006) examined Sweden's mandated reporting assessment process by reviewing 220 reports indicating child maltreatment. They found that 76% of reports indicated risks following the initial assessment by child protection teams. However, after a five-year follow-up of these cases, only 45% had been assigned to a social worker and the case fully investigated, leaving a concerning 55% of cases requiring follow-up. In Ireland, between January and March 2023, 49% of referrals requiring preliminary screening were completed within 30 days, and an additional 27% were completed within 40 days (Tusla, 2023). In June 2023, there were approximately 23,000 open cases of child abuse following an investigation, 25% of which (that is, 5,700 children) had not been assigned to a social worker who could monitor risk to the child and their family (Tusla, 2023). The goal of mandated reporting is to bring to light potential child at risk so that authorities can stop abuse and offer support services. Therefore, for a child protection system to be effective, it needs to be timely.

Mathews and Kenny (2008), in their review of differences in mandatory reporting laws, asserted that there is a lack of consensus on the advantages of mandatory reporting. They point out that certain countries, such as the UK and New Zealand, have yet to implement such laws as a result. They contend that mandatory reporting can lead to excessive reporting, harming

children and families by diverting resources. Moreover, Mathews et al. (2017) in a 20-year Australian longitudinal study comparing the reporting of child sexual abuse across gender found that reporting rates for child sexual abuse were influenced by factors such as social, political, and legal events, which leads to questions around its ability to uncover child abuse. Ainsworth (2002) investigated the reporting and substantiation rates in two Australian states: one with mandatory reporting and the other without, to determine whether children were abused less in states with mandated reporting. Findings suggested that jurisdictions with mandatory reporting have lower substantiated and higher notification rates, indicating that child protection services are overburdened. The authors concluded that the child welfare system has shifted its focus from providing services to children and families to forensic and investigative activities (Ainsworth, 2002). Other authors, Krase & DeLong-Hamilton (2015), Mathews & Kenny (2008), and Melton (2005), have reported similar findings.

When considering the reporting of sexual abuse, Mathews (2014) reported contradictory findings to Ainsworth (2002) in terms of substantiation rates. Mathews (2014) compared the reporting of child sexual abuse in two jurisdictions: Victoria, Australia and Ireland. Both countries shared similar cultural backgrounds, had comparable numbers of children, and similar demographics in terms of education, health, police systems, and wealth. The significant difference was that Victoria had mandatory reporting laws and a legislative duty to report sexual abuse. In contrast, in Ireland in 2010, there was no legal reporting duty. However, some professions were required to report based on the policy framework outlined in the Children First: National Guidelines for the Protection and Welfare of Children (Department of Health and Children, 1999). Mathews (2014) empirically analysed the reporting of child sexual abuse over 12 months in Victoria and Ireland. There were four key findings: (1) double the number of

reports were made in Victoria, 53% of which were made by mandated reporters; (2) a higher number of children were identified as being abused in Victoria (700); (3) 54% of all abuse cases identified were as a result of a mandated report; and (4) there was no apparent overburdening of the systems. The author recommended further research over extended periods. However, he concluded that "mandatory reporting of child sexual abuse produces substantial and superior outcomes in identifying children who have been abused, compared with an approach which does not include mandatory reporting" (Mathews, 2014, p. 477).

Advocates for mandatory reporting contend that countries with some form of legal reporting requirements have a higher substantiation rate (Palusci et al., 2016). Hutchison (1993) asserts that mandatory reporting is crucial for alerting authorities to cases of abuse, given that children cannot protect themselves and so require someone to act on their behalf. Additionally, she contends that abusive parents are unlikely to seek support voluntarily, while those working with children are in the best position to detect abuse. Matthews and Bross (2008, p.511) put forward the argument that "without a system of mandated reporting, a society will be far less able to protect children and assist parents and families, because many cases of abuse and neglect will not come to the attention of authorities and helping agencies."

In summary, despite a plethora of international empirical research, the evidence to support mandatory reporting as a mechanism to reduce the risk of children being abused is inconclusive. There are benefits to having such a system in operation; namely, it can provide early detection and interventions for children at risk or being abused. It can prevent further abuse by identifying people who may harm children, and it increases cultural awareness. However, for any system to operate efficiently, it must have adequate resources. Effective and robust systems must be used to screen reports, even if they are over-reported.

Having considered the current literature on mandated reporting as a form of child protection, focus will now shift to considering the literature on psychotherapy and working with trauma, and the lived experiences of clinicians and adult survivors as they work with mandated reporting in therapy.

Key Aspects of Psychotherapy and Working with Trauma

Corsini and Wedding (2018) defined psychotherapy as "a psychological treatment that involves a structured interaction between a trained professional and a client with the purpose of alleviating emotional distress, modifying maladaptive behaviour, and promoting personal growth" (Corsini & Wedding, 2018, p. 1). This interaction between the therapist and the client is also known as the therapeutic relationship. Gelso and Carter (1994) offer a wide definition of this relationship, which they describe as "the feelings and attitudes that counselling participants have towards one another and the manner in which these are expressed" (Gelso and Carter, 1994, p.297). Bordin's (1979) seminal work offered a conceptualisation of this therapeutic relationship as a 'working alliance' that is predicated on three critical components: goals, tasks, and the therapeutic bond. He posits that the presence of these elements, coupled with the maintenance of a robust working alliance throughout the duration of therapy, significantly enhances the likelihood of favourable treatment outcomes (Bordin, 1979). Nearly five decades after its introduction, Bordin's foundational theory continues to hold significant prominence in the literature on the therapeutic alliance (Ackerman & Hilsenroth, 2003; Horvath & Symonds, 1991). The Working Alliance Inventory (WAI), developed by Horvath and Greenberg in 1989, serves as a self-report instrument designed to quantitatively assess the strength of the therapeutic alliance between client and therapist. Empirical studies utilising this framework consistently

reveal that the quality of the therapeutic relationship stands out as one of the most robust predictors of counselling outcomes, often surpassing the predictive validity of specific therapeutic interventions (Knaevelsrud & Maercker, 2006). This assertion is further corroborated by a comprehensive meta-analysis of alliance-outcome research, which synthesised data from over 190 independent studies and concluded a modest yet statistically significant correlation between the quality of the therapeutic alliance and therapeutic outcomes (Arnow et al., 2013). Further studies by Norcross & Lambert (2019), Koole & Tschacher (2016), and Wampold & Imel (2015) have found similar results.

In their review paper, Ardito & Rabellino (2011) suggest that research consistently finds that the quality of the client–therapist alliance predicts treatment success across different therapies and diagnoses. These findings indicate that outcomes tend to be consistent across various therapy models, indicating the presence of common factors that positively impact change (Lambert, 1992; Wampold, 2001). Grencavage & Norcross (1990) explored these common factors and, in their study, reviewed 50 publications to discern commonalities across different therapies, identifying five universal factors that contribute to successful therapy: client characteristics, therapist qualities, change processes, treatment structures, and relationship elements**.** The client qualities included being in distress, actively seeking help and having positive expectations of therapy; the therapist's qualities included warmth, empathy, acceptance, and positive regard, together with an ability to cultivate hope. The therapist also influenced the change process by creating opportunities for catharsis, emotional learning, feedback and tension reduction, fostering insights and awareness, and providing information and education. The fourth factor is treatment structure, which includes therapeutic techniques and interventions, focusing on the client's internal/emotional world and the therapist's verbal and nonverbal communication.

Finally, the relationship elements include the development of the alliance, engagement with therapy and transference. Since the publication of this seminal study, a significant corpus of research has emerged that delves into the common factors influencing therapeutic outcomes. These factors are frequently categorised into client, therapist, and relational elements. Notably, the development and maintenance of the therapeutic alliance has been identified as a pivotal component of therapeutic outcomes. Empirical studies suggest that the relational dynamics inherent in psychotherapy account for approximately 30% of the variance in treatment outcomes across therapeutic modalities (Lambert, 2013). This underscores the importance of relational elements in enhancing the effectiveness of psychotherapeutic interventions and highlights the potential damage mandated reporting of childhood abuse can do to this critical aspect of the therapeutic process.

Another significant area of psychotherapy research has concentrated on understanding the mechanisms behind therapy, particularly by examining moments that clients identify as beneficial or detrimental, referred to as significant events (Elliot et al., 2001; Wampold & Imel, 2015). It is proposed that by thoroughly exploring and comprehending these pivotal moments, therapists can better understand the factors that facilitate their clients' healing processes (Greenberg, 1986). To support this exploration, various self-report questionnaires have been developed to assist clients in recognising helpful and unhelpful moments during therapy (Cummings et al., 1992; Elliott & Shairo, 1988; Llewlyn, 1994; Watson et al., 2012). Timulak (2007) conducted a meta-analysis of seven qualitative studies using these instruments, containing more than 590 therapy events from 94 different cases, with 94 participants, and found a set of helpful moments in therapy, including safety/reassurance/support and personal contact. The moments deemed within the category of safety were defined as instances where clients felt

accepted and reassured by the therapist, either through verbal or non-verbal cues, and included feeling supported. Personal contact refers to the client perceiving the therapist as a fellow human being rather than an expert or doctor and experiencing a sense of closeness. When working with adult survivors, the two fundamental factors of safety and connection must be considered, and according to trauma theorists Ogden & Fisher (2015), are the elements that are the cornerstones of trauma therapy. Therefore, it is essential to prioritise establishing a safe and secure environment for the survivor and fostering a strong therapeutic alliance built on trust and connection.

Building on the above study, Timuluk and Keogh (2017) provide a practice-friendly synthesis of recent research on clients' perspectives of therapy. They propose that a therapist's receptiveness to seeking out their client's perspectives, willingness to listen to their feedback without defensiveness, and ability to adjust their actions accordingly can all help foster stronger relationships and collaboration with clients. This, in turn, can lead to more positive therapeutic outcomes.

Considering what clients find unhelpful or hindering in therapy can inform psychotherapy practice. Ladmanova et al. (2022) conducted a meta-analysis of 13 qualitative studies, with 127 participants and found that clients reported a set of hindering impacts in therapy. These included feeling disconnected from the therapist; emotionally overwhelmed, confused, and pressured by the therapist; having difficulty disclosing thoughts and feelings and completing tasks; being aggravated or hurt by the therapist; and a lack of guidance from the therapist. According to these authors, negative experiences can hinder a client's participation and willingness to engage in therapy, thus impeding progress. They further suggest that to foster a strong therapeutic relationship, therapists should routinely inquire about their clients' level of

engagement and any discomfort they may be experiencing during sessions (Ladmanova et al., 2022).

Although psychotherapy has proven effective in numerous studies (Lambert, 2013; Moreno et al., 2023), around 30% to 40% of clients do not report any improvement from therapy (Lambert, 2011). Furthermore, around 20% of clients choose to prematurely discontinue or stop attending therapy sessions altogether, often without warning or notice (Swift & Greenberg, 2015). These findings are similar to those of Bryant & Baldwin (2010). A survey study, albeit potentially outdated, conducted by Steinberg et al. (1997), with 907 U.S. psychologists working with children, adolescents and families, specifically examined the dropout rates from psychotherapy following a mandated report. The findings indicated that 27% of clients discontinued therapy following the reporting process (Steinberg et al., 1997), which is in keeping with the more up-to-date figures for general dropout during therapy. These troubling trends have prompted researchers to delve deeper into the therapeutic alliance and any factors that may contribute to such statistics. The concept of rupture and repair in the therapeutic alliance (Muran and Safran, 2016), which describes a breakdown and repair (if possible) in the relationship between the client and the therapist, is relevant here. An alliance rupture can be characterised as "a tension or breakdown in the collaborative relationship between the patient and the therapist, as well as a difficulty in establishing a therapeutic bond early in the process" (Talbot et al., 2019, p. 20). Safran and Muran (2000) identified two primary types of alliance rupture. *Confrontation* ruptures manifest as hostile reactions from the client, directed towards either the therapist or the therapeutic process. These emotional responses are often rooted in anger, dissatisfaction, or resentment. In contrast, *withdrawal* ruptures occur when clients react to relational issues by becoming silent, withholding answers, offering minimal answers, or changing the subject.

The introduction of mandatory reporting by the therapist and the need to make a mandated report following a client's disclosure of childhood abuse can have the potential to create a rupture in the therapeutic alliance. Tufford and Lee (2020) studied mandatory reporting in psychotherapy, focusing on the impact on the therapeutic alliance after a mandated report – the rupture and repair. Using a mixed-methods approach, they surveyed 439 Canadian social workers about strategies to maintain this alliance. The qualitative data were analysed thematically, revealing six strategies for repairing the alliance at various stages of its development and maintenance. Firstly, prevention: explaining confidentiality limits and consequences of disclosures to build relationships; (2) reporting: being clear about the need to report and collaborate on reports; (3) information: providing details on the reporting process, CPS roles, and available support; (4) affect regulation: both the family and the therapist need to regulate their emotional response to the reporting process and the therapist supports families through their immediate experiences: (5) advocacy: reinforcing family strengths while advocating to CPS on behalf of at-risk children; and (6) resources: connecting families with relevant community resources. Tufford and Lee's (2010) study sheds light on Canadian social workers' strategies to repair the therapeutic alliance after child protection reports. However, it has limitations: reliance on an online survey may introduce self-reporting biases, and the thematic analysis could oversimplify the complexity of therapeutic relationships by categorising them into six strategies. Additionally, the focus on the social worker's perspective overlooks the experiences of children, adolescents, and families. Despite these issues, the study is the first to examine the effects of mandatory reporting on the therapeutic relationship regarding rupture and repair.

Findings about the therapeutic alliance, including the elements that contribute to or undermine its efficacy, as well as strategies for addressing ruptures within the therapeutic relationship, are important in the practice of psychotherapy. They underscore the diverse experiences of psychotherapy clients, irrespective of their reasons for seeking therapy, symptoms, or underlying psychological issues. Further targeted research has been conducted on specific populations of clients who present with similar concerns, such as anxiety, depression, panic disorders, eating disorders, and self-harming behaviours, among others (Caiseo et al, 2025; Sass et al., 2022). This focus has enabled researchers and practitioners to tailor interventions to meet the distinct treatment needs of these varied client groups, taking into account their therapeutic requirements, modalities, and approaches. For instance, clients with a history of childhood abuse represent a particularly vulnerable subgroup who need specialised therapeutic considerations, and will now be considered.

The Impact of Childhood Abuse – A Paradigm Shift

Researchers exploring the effects of childhood abuse and trauma have found that survivors are more susceptible to physical, mental, psychological, and relationship difficulties that can impact them throughout their lives (Mathews et al., 2017). The lifetime effects of child abuse and neglect have been widely researched within the fields of child protection, psychology, and trauma (Lippard & Nemeroff, 2020; Teicher & Samson, 2016). Children who have experienced abuse are at a significantly higher risk of developing a range of mental health issues, including anxiety, depression, post-traumatic stress disorder, suicidal tendencies, eating disorders, bipolar disorder, and other cognitive dysfunctions (Gould et al., 2012; Xiao, 2023). Substance misuse, including alcohol addiction (Min et al., 2007) and chronic physical health

conditions (Kendall-Tackett, 2002), are also common outcomes. As a result, adult survivors often seek support from mental health services, psychologists, counsellors, and psychotherapists (Henderson, 2013).

Over the past two decades, there has been a significant paradigm shift in approaches to healthcare, particularly in psychotherapy, regarding the support and treatment of survivors of childhood abuse and trauma. The publication of the Adverse Childhood Experiences (ACE) study in 1998 (Felitti et al., 1998) catalysed this transformation. Conducted in the United States, the authors of the ACE study employed qualitative methods and self-report questionnaires to assess adverse childhood experiences for 13,500 patients who had recently undergone medical evaluations within a large health maintenance organisation (HMO). A robust, graded relationship between exposure to childhood adversity and an array of health-related risk factors was found, underscoring the profound impact that early traumatic experiences can have on long-term health outcomes. However, a significant limitation of the study must be acknowledged: while a correlation between childhood adversity and increased health risks was established, causation was not demonstrated. Therefore, additional factors may have contributed to the elevation of risk factors and adverse childhood experiences.

Despite the limitations, these insights have sparked a re-evaluation of psychotherapeutic practices, leading to the emergence of more trauma-informed care models that acknowledge the complex interplay between psychological trauma and physical health (Cicchetti & Toth, 2005). Mental health professionals are increasingly incorporating these findings into treatment frameworks for individuals affected by childhood abuse and trauma (Briere & Scott, 2015). This approach fosters a comprehensive understanding of health that encompasses both psychological and physiological aspects. Instead of asking, “What is wrong with you?” practitioners might ask,

"What happened to you?" This transforms the view of survivors of child abuse from deficient or to blame to a recognition of the profound impact of childhood trauma on their lives (Fisher, 2021; Levine, 2010; Ogden et al., 2006; Hodgdon et al., 2022; Van der Kolk, 2014). Mandated reporters of childhood abuse should recognise that when abuse is disclosed, the person disclosing may also be a survivor, as is the case in historical/retrospective reporting.

Having examined the fundamental elements of psychotherapy and the intricacies of addressing trauma, attention will now shift to the ethical considerations surrounding mandated reporting during psychotherapy. This often presents a significant ethical dilemma for therapists, raising complex questions about client confidentiality, professional responsibility, and the potential impact on the therapeutic relationship.

Ethical Considerations for Psychotherapists

Mandatory reporting laws present ethical dilemmas for psychotherapists, particularly regarding balancing their duty to protect the children with their professional duty to individual clients. As discussed in the earlier sections, reporting can disrupt the therapeutic alliance, a foundational component of effective treatment (Doran, 2016). In their qualitative study, Schwab-Reese et al. (2023) conducted semi-structured interviews with 77 frontline workers involved in mandated reporting in Colorado (with mandated reporting) and the Netherlands (without). Their team-based analysis revealed concerns that mandated reporting could undermine trust in therapy, jeopardise treatment outcomes, and lead to premature termination when compared with therapy without reporting laws (Schwab-Reese et al., 2023). In a subsequent study by Strozier et al. (2005), a qualitative investigation using thematic analysis was conducted to explore the experiences of 101 family therapists in the United States regarding mandated reporting

obligations. While a subset of practitioners reported favourable experiences associated with mandatory reporting—such as an enhanced sense of professional accountability and an increased commitment to safeguarding vulnerable populations—many participants articulated concerns regarding the detrimental impacts on client engagement and the therapeutic alliance. These findings underscore the complexities of navigating ethical responsibilities in the context of mandated reporting within therapeutic settings. This ethical complexity is particularly pronounced in psychotherapeutic contexts, where the disclosure of abuse often involves profound vulnerability and emotional risk for the client. In their narrative review of therapeutic approaches for working with survivors of childhood sexual abuse, they alert clinicians to the risk that clients can perceive reporting of suspected abuse as a breach of confidentiality, leading to feelings of betrayal and mistrust (Crowe & Dare, 1998). As Roback and Shelton (1995) highlight in their systematic review of the literature, therapists must carefully navigate legal obligations, as they can unintentionally harm the individuals they're trying to support. This highlights the importance of nuanced, client-centred approaches that balance ethical duties to clients with legal responsibilities to society.

Ethical Codes and Principles

To support psychotherapists with these ethical challenges raised by mandated reporting, ethical codes and principles offer guidance and support. Codes of ethics in counselling and psychotherapy are formal documents that outline the professional values, principles, and standards of conduct that guide the behaviour of counsellors and psychotherapists. They serve as the ethical backbone for psychotherapeutic practice, offering structured guidance for navigating complex clinical situations. Globally, many professional organisations represent and support

counsellors and psychotherapists. Each has its own code of ethics, all of which are built on the four pillars of medical ethics—namely, autonomy, beneficence, non-maleficence, and justice (Boyd, 2005)—and four key principles: respect, competence, responsibility, and integrity. For instance, in the USA, the American Counseling Association (ACA) is the largest organisation for counsellors and psychotherapists. Their Code of Ethics includes clear directives regarding counsellors' duty to report suspected child abuse or neglect. It affirms that maintaining professional integrity and ethical care must accompany adherence to legal requirements and acknowledges the need to breach confidentiality when adhering to mandated laws. Mental health counsellors, licensed or in training, are explicitly obligated to report any suspicions of child abuse, including historical events (ACA, 2014).

In Ireland, confidentiality in counselling and mandated reporting obligations mirror complexities found in the U.S. The Irish Association of Counselling and Psychotherapy (IACP) offers limited guidance, stressing the importance for practitioners to inform clients about the limits of confidentiality, especially regarding child protection reporting. Additionally, IACP members are required to "be familiar with and comply with current child protection legislation" (IACP, 2018, p.3). The Irish Association of Humanistic and Integrative Psychotherapy (IAHIP, 2018) outlines clear directives on reporting duties in its Code of Ethics, emphasising the protection of children and vulnerable adults. It details the reporting requirements, thresholds, and the importance of consulting with Tusla. The code also stresses that practitioners must be aware of their statutory obligations. Despite varying levels of detail, both ethical frameworks offer vital guidance on best practices and underscore the importance of safeguarding vulnerable populations in therapy.

Professional ethical principles form the foundation of ethical codes, serving as a framework of rules that establish appropriate actions within certain professions, thereby promoting integrity, accountability, and respect for individuals and communities (Tribe & Morrissey, 2020). These foundational principles often encompass honesty, trustworthiness, loyalty, fairness, and adherence to legal standards. Such ethical tenets guide professionals toward making judicious decisions that uphold public confidence and create a supportive work environment (Pope & Vasquez, 2016). Moreover, adherence to these principles is crucial for navigating the complexities of ethical dilemmas and advancing ethical standards within the profession (Barnett, 2019). The ethical principles that underpin the practice of psychotherapy and guide the associated codes of ethics are vital for ensuring professional integrity and client welfare. Among these principles, two stand out as particularly relevant to this study on psychotherapy and mandatory reporting: confidentiality and informed consent (Anderson & Handelsman, 2009). These concepts will now be examined in detail, along with their relevance for safeguarding client welfare while navigating the complexities of mandatory reporting obligations within therapeutic practice.

Confidentiality and Informed Consent

Within psychotherapy, confidentiality is a fundamental cornerstone that fosters trust and enables clients to share sensitive information (Corey, 2023). However, this principle is challenged by mandatory reporting laws, particularly in cases involving historic or retrospective child abuse. Therapists must balance their ethical duty to protect the client's trust with legal and ethical obligations to report. The disclosure of historical abuse presents unique ethical challenges compared to current abuse cases. This complexity arises because the victim being reported is

often an adult survivor with the agency to make their own decisions. In contrast, cases of ongoing abuse, where the perpetrator is the abuser or third-party disclosures, do not raise the same ethical concerns regarding autonomy and decision-making. Thus, historical abuse disclosures are ethically more intricate. Like mandated reporting and psychotherapy, published studies specifically focusing on this cohort of psychotherapy clients (adult survivors of childhood abuse) do not exist, so a general understanding must be drawn from broader studies. One such U.S study by Kremer and Gesten (1998) involved 91 active psychotherapy clients from various therapeutic settings and 148 college students who were not in therapy. The research aimed to compare how willing participants were to share information during therapy under three different conditions that offered varying levels of confidentiality. Data analysis via repeated-measures analysis of variance showed that psychotherapy clients and college students were less willing to self-disclose when uncertain about confidentiality. The authors suggest that therapists should make a conscious effort to ensure that clients clearly understand the boundaries of confidentiality. By openly discussing these limits, therapists can promote a stronger sense of trust and engagement in the therapeutic process, which can benefit both the client and the therapy itself. Although this is an outdated study, it does show that understanding the limits of confidentiality is important for clients to continue self-disclosing, which is a key component of psychotherapy, and that therapists can play an active role in providing clients with information that builds trust and safety. In a qualitative study conducted by Deisz et al. (1996), which included a sample of 49 therapists and child protection workers, the findings revealed congruent results.

Therapists express greater comfort articulating the parameters of confidentiality in therapeutic relationships when these parameters are clearly delineated, particularly as defined by

legal statutes. Conversely, they report increased discomfort in situations where the boundaries of confidentiality are less unequivocal and potentially more multifaceted, such as in contexts involving court mandates or legal proceedings (Elger et al., 2015). In a study by Duncan et al. (2012) involving 264 Australian psychologists, researchers explored the decision-making process surrounding breaches of confidentiality with adolescents. Participants rated 13 considerations, and factor analysis revealed that maintaining the therapeutic relationship, when a breach was necessary, was a key factor. The study highlights the necessity of "open and honest communication from the beginning of therapy, in order to minimise the possibility of the breach having a lasting negative impact on the young person" (Duncan et al., 2012, p. 217). The authors highlight that failing to discuss confidentiality can harm the therapeutic alliance, undermining client trust and therapist integrity (Duncan et al., 2012). Clear communication about confidentiality is vital for a supportive therapeutic environment. While this study focused on adolescents, it enhances our understanding of confidentiality in therapy, stressing the need for therapists to address it from the start and throughout the process. This aligns with Tufford and Lee's (2020) (see above) insights on the dynamics of rupture and repair after a mandated report, emphasising the importance of open dialogue, especially when legal obligations arise. Understanding confidentiality and its limits fosters trust and empowers client autonomy to make decisions about what information they wish to share and the potential consequences (Elger et al., 2015).

Moving to consider the second ethical principle relevant to psychotherapy and mandated reporting: informed consent, a core principle embedded within professional codes. Informed consent is an ongoing process where the therapist gives the client clear information about psychotherapy's nature, purposes, risks, benefits, alternatives, and confidentiality limits, allowing

the client to make an informed and voluntary decision to participate in treatment (Beahrs & Gutheil, 2001; Pomerantz, 2005). It is built on the ethical principle of autonomy, which emphasises respect for the person (Beaumont & Childress, 2019). The primary objective of informed consent is to empower individuals seeking psychotherapy to exercise autonomy over their mental health decisions, thereby enabling them to make choices that reflect their distinctive values and aspirations. To achieve this, it is imperative that clients receive comprehensive, understandable information about the therapeutic process. Such clarity facilitates informed decision-making regarding their engagement in psychotherapy (Appelbaum, 1997; Darby & Weinstock, 2018). This foundational principle not only fosters client autonomy but also upholds ethical standards within the therapeutic relationship. In Ireland, to respect client autonomy, the 'Children First' guidelines require therapists to inform clients that disclosures of past or ongoing abuse may trigger a legal duty to report (Department of Children and Youth Affairs, 2017). Clearly communicating this responsibility early on respects client autonomy, reinforces ethical standards, and fosters informed decision-making in therapy (Darby & Weinstock, 2018).

The empirical evidence regarding clients' experiences of informed consent in psychotherapy is limited, despite it being a fundamental component of the ethical codes established by psychotherapy organisations. Lamont-Mills et al. (2018) undertook a systematic review of the literature to "examine empirical evidence related to client understandings of informed consent and/or confidentiality".(Lamont-Mills et al., 2018, p. 1). Their search revealed no research specifically focused on informed consent during therapy. However, two studies did reference the topic. The first, conducted by Zhao et al. (2012), examined clients' perspectives on their therapists' ethical practice, which included whether clients received information about the costs and risks of therapy prior to starting treatment, thereby addressing aspects of informed

consent. This study surveyed 1,274 Chinese psychotherapy clients utilising a specifically designed questionnaire. The data was analysed for frequency distributions, revealing that 50% of respondents reported receiving information about therapy costs, while approximately 30% reported that their therapist discussed the risks of therapy. These findings raise questions about therapists' adherence to their ethical codes, as only half of the clients recalled receiving this information, despite it being explicitly stated in the codes of ethics.

The second study, Walfish & Ducey (2007), based in the U.S., evaluated the readability of written informed consent forms used by psychologists. They found that the forms were written using language graded as 'high difficulty', which the authors suggest risks clients not being able to understand the forms and therefore not truly giving informed consent because of a lack of understanding. They further suggest that informed consent forms are reviewed from the client's rather than the therapist's perspective.

In contrast, McGregor et al. (2006) focused directly on the psychotherapy client's experience. They explored what adult survivors found helpful and unhelpful in therapy, although not directly addressing informed consent, the findings add valuable insight into the client's experiences. This was a mixed-methods study conducted in New Zealand; 191 women participated in the quantitative questionnaire, of whom 20 were selected for qualitative interviews. The interview data were analysed using grounded theory. Participants reported finding it beneficial when therapists explained the therapy process, including confidentiality and its limits, as well as their rights. They reported feeling empowered and equal, as if they had more control over the process. One of the benefits of this study is that survivors of abuse were treated as a distinct and homogenous group whose needs differ from those of other psychotherapy clients. Although mandatory reporting and informed consent were not explicitly addressed, and

the sample size is relatively small, the necessity of contacting (the process of gaining informed consent in therapy), explaining the limits of confidentiality and the therapist's legal responsibilities as a mandated reporter when working with this client group is addressed, and it is one of the few studies that gives voice to the experiences and voices of the psychotherapy client.

Codes of ethics play a vital role in empowering psychotherapists to effectively navigate the ethical challenges that arise with mandated reporting. By promoting consistency and transparency while encouraging thoughtful decision-making, these codes are essential in minimising harm and supporting both legal compliance and the effectiveness of therapy. Confidentiality and informed consent are at the centre of ethical psychotherapy practice and play a vital role in protecting the client and the therapeutic relationship when the need to make a mandated report arises in therapy. However, from the limited research available, it is evident that there is a need for more empirical research to strengthen these guidelines, ensuring that the needs of clients are met alongside those of therapists. Having considered the ethical considerations of psychotherapists when working with mandated reporting attention, this chapter will now move to examine mandatory reporting and psychotherapy.

Mandatory Reporting and Psychotherapy

Psychotherapy is characterised as an evidence-based practice that effectively integrates empirical research, clinical expertise, and client values rather than merely adhering to standardised treatment protocols (APA, 2006). Consequently, it is imperative for psychotherapists to leverage empirical research to inform their clinical practice and gain a comprehensive understanding of their clients' needs. This section critically evaluates the

empirical evidence on mandated reporting in psychotherapy. The predominant body of research in this area has focused on therapists' experiences and perceptions, along with their understanding of clients' experiences related to mandated reporting. In contrast, there is a notable lack of studies that directly investigate the clients' perspectives. To effectively synthesise the existing knowledge on the intersection of mandated reporting and psychotherapy, this analysis will provide a consolidated overview of the pertinent literature and, where appropriate, include broader studies on mandated reporting. Due to the concerning lack of recent research on the topic under investigation and the many existing studies being outdated, incorporating these earlier works is crucial, as they offer valuable insights into what is currently known about the dynamics between mandated reporting and therapeutic practices.

Trust is a key component of psychotherapy and the therapeutic relationship (see sections above – key aspects of psychotherapy and confidentiality and informed consent). Therapists rely on a foundation of safety and confidentiality, which encourages clients to disclose sensitive experiences (Kremer & Gesten, 1998). However, when clients become aware that certain disclosures will trigger legal obligations, this can be perceived as a breach of trust or a betrayal, particularly in cases involving historic child abuse (Kelleher et al., 2012) (see section below – clients' experience of mandatory reporting for details of the study). A recent study by Bean et al. (2011) corroborates the findings of Kelleher et al. (2012), around feelings of betrayal, but from the therapist's perspective and experience. Bean et al. (2011) conducted a qualitative case study examining the implications of mandated reporting on therapeutic relationships, centred on a case involving a 13-year-old female client and an 18-year-old male. The study details the therapist's procedures in response to the reportable situation and highlights the client's and her family's

emotional reactions, emphasising that clients may perceive the reporting process as a betrayal, particularly as they begin to assert their autonomy. The authors argue the importance of processing these emotional responses within a therapeutic framework to promote healing and maintain the relationship. Another finding from this study was that the therapists may struggle with ethical dilemmas, fearing that mandatory action could undo therapeutic progress or be perceived as aligning them with former perpetrators or failing adults. They also discuss the therapist's uncertainties regarding reporting obligations and the importance of supervision and consultation in such circumstances. While this study offers a unique, in-depth clinical application of the issues with mandated reporting in therapy and valuable insights into clinicians' experiences of the clients' feelings of betrayal, its single-case design limits generalisability and does not assess clients' understanding or experience of the reporting process.

The idea of therapists feeling similar to perpetrators of abuse in their role as mandated reporters is also shared in an Irish study. Pellegrini et al. (2022) conducted a qualitative focus group study, using thematic analysis to explore the reporting experiences of 18 Irish psychologists. Within the theme – impact on the psychologist, findings detail how participants felt forced into adopting the role of abuser by having to take action that they knew would hurt their client, one participant said "it puts me in a position of feeling like an abuser … I feel like I am actually betraying someone's trust, I'm bring back that sense of powerlessness that they experienced in childhood" (Pellegrini et al., 2022, p. 1097). McNay et al. (2012) and Teram et al. (1999), in their papers on disclosure of childhood abuse, both emphasise how survivors of childhood abuse often have deeply fractured trust due to previous violations, and mandated reporting can inadvertently replicate those dynamics, as highlighted in both Pellegrini et al. (2022) and Bean et al. (2011). They also assert that clients may feel exposed or retraumatised,

especially if reporting occurs without them fully understanding the implications (see section above on confidentiality and informed consent). These findings, along with the other studies above, suggest that reporting harms the therapeutic relationship by bringing betrayal into the therapy, both for the client, the betrayed and the therapist, the betrayer or abuser.

The idea that mandated reporting may be harmful, traumatic or retraumatising, as in the case of historic or retrospective abuse, has long been offered as a disadvantage of reporting (Berlin, 2014; Buckley, 2012; Feng et al., 2012). This was the focus of a systematic review of empirical literature by Havig (2008). Published peer-reviewed articles between 1990 and 2006 concerning the experiences of adult survivors of sexual abuse in healthcare settings were reviewed (mandated reporting was not the focus of these studies, but it was mentioned). Ten studies were included in the review: nine qualitative and one mixed methods (*n*=1,487). Findings suggested that disclosure of abuse can be psychologically distressing for the survivor, and the formal nature of reporting may intensify feelings of vulnerability and powerlessness. Sensitive communication strategies, such as allowing paced disclosure and avoiding overly clinical environments, are crucial for minimising distress (Havig, 2008).

McTavish et al. (2017) conducted a meta-synthesis of qualitative studies examining mandated reporters' experiences with reporting. These studies included all types of mandated reporters, not just psychotherapists and were conducted in 12 countries, including the U.S. and Australia. Forty-four articles were included, covering 42 studies and representing the views of 1,088 mandated reporters. Findings showed that 75% of reporters had negative views and attitudes towards reporting, whilst 25% had positive views – these percentages also reflected participants' experiences with reporting. Negative experiences included struggles and hesitation

to identify and report less obvious forms of abuse, negative child outcomes following reporting (in one study, reporting resulted in the death of a child), the lack of feedback following the report, and fear about the consequences of reporting. The authors conclude that the negative experiences are deeply concerning, especially since reporting, in some cases, did not ensure that the children at risk were safe. Many of the articles (86%) commented on the need for mandated reporters to be adequately trained to respond to and report abuse, for better support for reporters, and for clear reporting protocols. The authors acknowledge that the study did not focus on the children's or caregivers' experiences with mandated reporting and suggested further research in this area.

Mandated reporting is not always associated with harmful outcomes. In a published systematic review of the process and consequences of mandated reporting, Alvarez et al. (2005) argue that mandated reporting does not universally harm therapeutic relationships. Supporting this, Watson and Levine (1989) analysed therapy records of 65 child and adolescent clients from a U.S. outpatient clinic to assess the impact of mandated reports on therapeutic relationships. They defined outcomes as positive if clients continued therapy after the report, negative if they discontinued or exhibited resistance, and neutral if there was no change. Over 50% of reports occurred within the first three months of therapy. Their quantitative analysis revealed that only 4% of clients discontinued therapy, while 25% experienced no change, and 71% maintained a positive therapeutic relationship. Similarly, Weinstein et al. (2000), in a qualitative survey of 176 U.S. mental health professionals, examined their experiences with reporting. Results showed that approximately 73% of clients exhibited either a positive change or no change following mandated reporting (23% left therapy following the report). Positive outcomes were associated with a better-quality relationship, longer time in therapy before the report was made, and a more

effective handling of the report by the therapist. This included informing about confidentiality and its limits, and being direct and forthright in the reporting. Although these studies may not meet current methodological standards, they do suggest that mandated reporting does not always undermine the therapeutic process and may, in certain contexts, be beneficial, going some way to reassure therapists that it is possible to fulfil their legal obligations while preserving client relationships. In their book, Levine and Doueck (1995) offer potential benefits of reporting on therapy, including strengthening the alliance, therapeutic use of the report, and obtaining necessary services. However, despite these findings, even small numbers of harmed or traumatised people as a result of mandated reporting represent a critical concern.

The importance of therapists, as mandated reporters, receiving necessary and adequate training to be able to identify, report and manage child abuse has consistently been raised as another barrier to reporting and potentially impacting on the mandated reporters' ability to effectively manage the reporting process and thus impact the client (Brown et al., 2024; McTavish et al., 2017; Wilson, 2021). In a Scottish qualitative IPA study, Chouliara et al. (2011) explored the perceptions and experiences of adult survivors and professionals working with them in a talking therapy service for child sexual abuse. Thirteen survivors and 31 professionals were interviewed. Although mandated reporting was not the focus of the study, participants discussed it. The professionals discussed how the reporting process impacted trust in the therapeutic relationship and their struggle to support the survivor while meeting their legal responsibility, which they described as ‘disloyal’ and ‘exposing’ for both the survivor and the professional. In their recommendations, they stress the importance of training for therapists so that they are able to respond to disclosures appropriately and empathically, decreasing the risk of distress for the

survivor and the potential of vicarious trauma for the therapist. Bragança-Souza et al. (2024) offer support for the need for adequate training for reporters. In their scoping review of literature concerning issues with the identification and reporting of child physical abuse by mandated healthcare professionals, they found that systemic factors, such as uncertainty around reporting procedures or insufficient practitioner training, contribute to therapists being hesitant or inconsistent in their responses to physical abuse reporting (Bragança-Souza et al., 2024).

Wijma et al. (2007) designed an original study that used a mixed methodology that combined patient narrative, sociological theory, and medical records to explore the complexities surrounding the silencing of adult survivors. While the authors highlighted the nuanced approach survivors often take in sharing their experiences—such as starting with a neutral aspect of their story to gauge the professional's receptiveness—the use of a 'testing strategy' to determine trustworthiness in a therapist highlights a significant issue in therapeutic relationships. It highlights a fundamental flaw in the dynamics of disclosure, where survivors feel compelled to censor their experiences based on the anticipated reactions of their listeners. This is troubling given the power imbalance present in clinical settings. Furthermore, therapists must navigate the tightrope between adhering to mandatory reporting requirements and allowing the patient's narrative to unfold organically, demonstrating the complexities of therapeutic practice. When initial disclosures are met with intrusive questioning and potential reporting, the likelihood of the survivor feeling safe to share more profound elements of their story diminishes significantly. This can perpetuate a cycle of silence and trauma, thereby reinforcing the issues clients have sought to address. While the study's findings may not be generalisable, qualitative insights into the impact of the clients' narrative demonstrate the need for more compassionate and patient-centred approaches to handling sensitive disclosures. Professionals must be aware of these

dynamics and strive to create an environment where survivors feel empowered to share their full stories without fear of judgment or repercussion. The study raises questions about the adequacy of current therapeutic practices and the potential harm they can cause if practitioners are not attuned to their clients' lived realities (Wijma et al., 2007). Having considered the impact of mandated reporting on psychotherapy, attention will now consider the personal impact on the therapist.

The Personal Impact on Psychotherapists

Mandatory reporting obligations place considerable emotional and role strain on psychotherapists, particularly when navigating the conflict between legal duties and the therapeutic alliance. In their article, Tufford et al. (2010) used a clinical case study of mandated reporting in family therapy to explore how the therapist attempted to maintain the therapeutic alliance in the face of reporting and to provide a holding environment for the couple. In this study, the therapist discusses how the reporting process elicits feelings of anxiety, helplessness, and ethical dissonance. How feelings of discomfort and trepidation about the possibility of raising mandated reporting and the consequences for the therapeutic relationship led to the therapist delaying discussion about reporting. How feelings of fear and powerlessness arose as a result of the client's threat to report the therapist to her governing institution. The authors recommend that clinicians develop an awareness of, and support for, their emotional responses to reporting and be conscious of how this can potentially impact their decision-making processes around reporting. (Tufford et al., 2010). This distress is amplified when therapists lack adequate institutional support, leading to professional isolation and diminished well-being, as suggested

by Stige et al. (2022) in their qualitative meta-ethnographic comparative study based on 14 studies (10 survivor studies and 14 professional studies) (n=812) across 6 countries.

Burnout, compassion fatigue and secondary trauma are prevalent among psychotherapists working with trauma, especially when it involves child abuse (Sprang et al., 2008; Killian, 2008; Newell & MacNeil, 2010). When mandatory reporting requirements further compound this work, the risks faced by therapists are exacerbated, primarily due to their recurrent exposure to traumatic disclosures and the significant emotional burdens associated with the reporting processes (Bean et al., 2011 - see above for details). This can lead to emotional exhaustion, intrusive thoughts, and reduced professional efficacy (Ross et al., 2008). Similar findings were found by Vaughn and Booth (2014) in their study with mental health professionals' experience of mandated reporting.

In Pellegrini et al.'s (2022) study (see above for details), psychologists reported the emotional response to their role as mandated reporters as anger, stress, sadness, depression, worry and frustration. They reported being "tormented with excessive ruminations, and they engaged in maladaptive coping strategies like dissociation and avoidance to manage" (Pelligrini et al., 2022, p. 1097). Similar findings emerged in a qualitative study using thematic analysis of the experiences of four psychotherapists with mandated reporting (Price, 2016). Other findings on the impact of reporting on the therapist include how the disruption of client trust during reporting exacerbates therapists' guilt and self-doubt (Tufford et al., 2019). Legal ambiguity, fear of error, and systemic inefficacy further contribute to chronic stress (Stige et al., 2022; Takis, 2008). Therapists may also experience moral distress when they feel that they are complicit in systemic failures (Tanner, 2012), while unresolved trauma can impair care quality and result in professional withdrawal (Kuruppu et al., 2018; McTavish et al., 2017). Long-term exposure to

mandatory reporting without adequate support increases the risk of burnout, secondary traumatic stress and emotional burden, underscoring the need for systemic interventions (Armes et al., 2020; Walsh et al., 2012). The findings from these studies demonstrate the personal toll mandated reporting has on the therapist, which, to some degree, may impact their clients.

Therapists also face legal and professional risks when they are required to report. Concerns include potential legal liability following unsubstantiated reports, client backlash, and reputational harm (Tufford et al., 2019; Steinberg et al., 1997). Broader systemic challenges, such as under-resourced child protection services, the design of policies that effectively influence diverse professions, and policies that can be politicised, undermine confidence in the process (Strozier et al., 2005; Vallett, 2023). Tanner (2012), in an unpublished U.S. qualitative doctoral thesis that used grounded theory to explore the mandatory reporting protocol for fairness and equity, suggests that intersectional factors such as gender, culture, and socio-economic status influence reporting dynamics, meaning therapists must navigate these complexities with limited guidance (Tanner, 2012). Such findings have been further explored by Drake et al. (2009). These risks highlight the necessity for clearer policies and improved interdisciplinary collaboration to ensure ethical and legally sound practices. Additionally, there is a critical need for greater support and training for psychotherapists in their role as mandated reporters. After exploring the perceptions and experiences of psychotherapists (both personal and professional) regarding mandated reporting, attention will now turn to the experiences of psychotherapy clients.

Psychotherapy Clients' Experience of Mandatory Reporting

Insights into clients' experiences of mandated reporting during therapy have mainly been reported by mandated reporters (as seen in the various studies highlighted in this review). One of the most recent and comprehensive is Pellegrini et al.'s (2022) Irish study (see above for details). The psychologists reported their perceptions of the mandate process on the therapy clients. The therapists noted that clients often experienced detrimental and harmful effects from the reporting process, particularly with retrospective reporting. They observed that clients refrained from discussing sensitive topics out of fear of triggering mandated reporting, resulting in a culture of silence and self-policing. Disengagement from therapy happened at two points: when the limits of confidentiality were discussed and after the report was made. This awareness of confidentiality limits undermined the therapeutic alliance, resulting in broken trust and heightened emotional distress for clients, including fear, anger, and sadness, post-report. Additionally, the mandatory reporting process mirrored abusive dynamics, stripping power from the victim. These findings raise significant concerns regarding the therapeutic relationship; however, it is important to note that these perceptions reflect the therapists' views rather than the clients' experiences.

A study that privileges the client's voice, and detailed above for the clinicians' experience, is Chouliara et al. (2011), a Scottish IPA study, which explored the perceptions and experiences of therapists and adult survivors about a talking therapy service for child sexual abuse. Thirteen survivors were interviewed. The survivors described reporting issues as "scary" (p. 145) and requested that reporting procedures be explained to them in more detail and that they be included in the reporting process to ensure some degree of control. From this study, it is clear that clients

want information about reporting and inclusion, with reporting a collaborative process between the therapist and the client.

One of only two studies that directly investigates the client's experience in the context of mandated reporting during therapy is an unpublished mixed-methods doctoral thesis by Rokop (2003). This study explores the intricacies of clients' experiences with mandated reporting, emphasising the dynamics of the working alliance and the interrelationships among client characteristics, therapist attributes, and the therapeutic relationship itself as they pertain to both positive and negative reporting experiences. The research involved eleven participants, all of whom were engaged in therapy and were subjects of mandated reports indicating that they posed a risk to a child. Utilising self-report measures to assess the working alliance alongside a tailored set of interview questions informed by Bordin's working alliance model of psychotherapy, the author conducted semi-structured interviews, which were subsequently analysed phenomenologically. The findings revealed that positive reporting experiences were associated with specific client characteristics, such as self-referral, pre-existing strong therapeutic relationships, continued engagement in therapy post-report, an inclination to forgive the therapist, and an intrinsic motivation for therapeutic progress. In cases of positive reporting experiences, therapists were perceived as open and transparent regarding their mandated responsibilities, albeit expressing reluctance about the reporting process. These therapists effectively managed the reporting trajectory, demonstrating empathy and remorse about the necessity of the report, while also providing supplementary support to their clients.

Conversely, negative reporting experiences were linked to various factors, including therapist inexperience, inadequate directness or clarity regarding their reporting obligations, a

lack of a robust working alliance prior to the report, and diminished empathy. Additionally, confusion surrounding confidentiality emerged as a significant contributor to negative experiences. Despite the varied experiences of the participants, a consensus emerged regarding the efficacy of therapy, with many individuals indicating a willingness to either return to therapy or to engage in it again. The predominant adverse effect reported concerning future help-seeking behaviour was a limitation on self-disclosure.

The implications of this study are critical for enhancing understanding of clients' experiences with mandated reporting, underscoring the profound influence of the therapist's competency, attitude, and proficiency on these experiences. However, it is essential to acknowledge the study's limitations. The qualitative analysis is somewhat vague, and the sample size restricts the generalisability of the findings. Furthermore, the participants represented the subjects of the mandated report—the alleged perpetrators—thereby raising questions about the applicability of the findings to survivors of abuse whose experiences are reported during therapy. Nevertheless, this study serves a vital function by illuminating and giving voice to clients' experiences within the mandated reporting framework.

The second study, which focuses on clients' experiences, draws from a similar population of therapy clients. In a qualitative study by Kelleher et al. (2012). In this study, thematic analysis was used to explore the experiences of six participants attending a residential, Australian-mandated, family enhancement program. This program offered early interventions to families where the parents were responsible for child abuse and neglect. Participants were considered especially vulnerable as they were under scrutiny from child protective services and were economically, educationally, and socially disadvantaged. Additionally, five out of the six participants reported experiencing child abuse themselves. All participants engaged in skills

development and group therapy sessions. Semi-structured interviews were conducted to collect data on participants' experiences with mandated reporting. Participants reported a conflict between the positive feelings they developed for the therapist and their negative feelings about their role as mandated reporters. This led participants to withhold information from the therapist and to avoid seeking help when required. In situations where information had to be reported to Child Protective Services, participants reported feeling "betrayed, frustrated and angry" (p. 106). However, despite this, trust had already developed in the therapeutic relationship, allowing participants to feel empowered to confront and resolve issues with the therapist. This study is vital as it sheds light on participants' initial responses to mandatory reporting and demonstrates how a strong relationship can help alleviate these emotions. However, the study's conclusions are constrained by the limited number of participants, each participant's individual circumstances, and the fact that the therapeutic work was conducted in a group rather than one-on-one therapy. Finally, as with the study by Rokop (2003), the clients were alleged abusers, but for many, also survivors of childhood abuse, and it was their offending behaviour that was being reported.

The aforementioned studies collectively highlight a significant deficiency in the existing literature regarding clients' experiences with mandated reporting in therapeutic settings. While inquiries into therapists' perceptions regarding clients' encounters with mandated reporting have generated a useful body of research, this perspective remains inherently limited. Melton et al. (1995) articulated that research focused specifically on mandated reporting and psychotherapy was "essentially absent" and identified a persistent "gap" (p. 53) in the clinical literature addressing the experiences of adult clients subjected to these statutory mandates during therapy.

They further contend that this deficiency reflects broader neglect of participants' experiential perspectives within the formal child protection framework (Melton et al., 1995, p. 53). Similarly, Steinberg et al. (1997) called for empirical investigations to explore client experiences, positing that “investigation is needed to assess client reactions and perspectives with regard to mandated reports” (p. 121). Despite the passage of approximately twenty-five years, this gap persists, as noted in the most recent investigation into mandated reporting and psychotherapy, which posits that “further research could … seek out the voices of clients who have undergone the mandated reporting process to capture their experiences” (Pellegrini et al., 2022, p. 1104). This enduring absence of client-centred research underscores a critical area for future inquiry within the field.

Conclusion

Child abuse poses a significant threat to children. The ratification of the UNCRC exemplifies the global effort to protect children. However, the most effective methods of detecting and responding to child abuse remain unclear. Mandatory reporting as a means of detection requires a delicate balance, as highlighted in the literature (Strozier et al., 2005; Tufford, 2018; Watson & Levine, 1989). Researchers must fully understand the experiences of those impacted by mandatory reporting. In the Irish context, researchers are beginning to address this gap by speaking to clinicians rather than survivors (Pellegrini et al., 2022; Price, 2016). This study will advance the literature by offering a unique insight into how clients experience mandatory reporting during psychotherapy and, as such, has the potential to enhance psychotherapy practice and training. The aim of this study is to reveal the experiences of adult survivors who have undergone therapy in which their abuse was reported. The primary goal is to contribute to the development of counselling and psychotherapy practices and training, as well as

going some way to fill the gap in the literature by adding to the growing body of research on mandatory reporting and therapy. Most importantly, adult survivors of affected by mandatory reporting will be given a voice in the study, as their perspectives are rarely represented in the empirical literature on this subject.

Researcher's Reflective Comment

As I began the literature review, I was surprised and overwhelmed by the volume of empirical studies investigating mandatory reporting. Initially, my focus became lost in the vast literature on this topic and the debate around the effectiveness of mandatory reporting to detect risk and harm to children. However, reading about survivors' experiences of disclosing childhood abuse in empirical studies helped me regain my focus, which was clients' lived experience of the phenomenon of mandatory reporting. It then became clear to me that I was drawn to hearing and learning from the survivors' lived experiences rather than statistics, reflecting my determination to adopt a qualitative phenomenological approach for this study. It also became evident that this approach was consistent with my person-centred approach to clinical practice.

As I searched for studies on whether reporting retrospective abuse helps to identify current risks to children, I became disheartened. The central premise for the inclusion of the mandatory reporting of retrospective childhood abuse was sparse. This caused me to question the risk-benefit of retrospective abuse, which is included in the Irish mandatory reporting laws.

At the start of this review, I was an advocate of mandatory reporting. During my years of working with adult survivors of abuse, I have witnessed the lifelong damage inflicted by abuse and thought that any measures which might lead to the identification of perpetrators and reduce child abuse were a good thing. However, my opinion shifted as I read more about the impact of mandatory reporting on systems, survivors, their families, and communities, as well as the lack of resources available. This shift has been gradual, and as I concluded the literature review, I moved closer to 'the fence' and had more questions than answers about the best way to protect children.

As I drafted and re-drafted this chapter, the feedback I consistently received from my supervisors was to focus less on the abuse and more on the research question. Earlier drafts were full of definitions of abuse, the history of child abuse and its impact on survivors. It took me some time to reflect on this feedback, as I had some strong defences, believing that abuse was important because, without it, there would be no mandatory reporting. However, I came to realise that, as my supervisors had pointed out, my view was skewed towards the abuse and not the reporting or the therapy. I wondered if this was some sort of parallel process for me as a researcher, as I tried to write this chapter. As clinicians with dual roles as mandated reporters, when a client discloses childhood abuse, does our focus become skewed to the abuse? - does it fit the definitions? does it meet the threshold, and the abuser? Are they dead or alive? how old are they? Do they have access to children?. Are we trying to piece together the information disclosed to see how it fits the reporting criteria? Is this what I was doing in earlier drafts - focusing on what needed to be reported rather than the reporting itself? I think perhaps it was. Once I realised this, and that the client's experience was being overshadowed by my focus on the abuser and the abuse, it was easy to refocus my attention on the client and their experience of the therapy and the reporting process. In my clinical practice, I have noticed a shift when reporting comes in. Instead of focusing on the reporting process, I take a breath and remind myself to stay with the client and their disclosure first and foremost, and to trust that the rest will follow.

Chapter Three:
Methodology

'The best research you can do is talk to people.'

(Sir Terry Pratchett, n.d)

Introduction

This chapter begins with an overview of the study's aim and objectives. Following this, a justification for the selected methodology will be presented. A summary of the philosophical foundations of interpretive phenomenological analysis (IPA) will be provided, along with a critique of this methodology. The discussion will then shift to the research methods, including sampling and recruitment processes, a summary of participants' demographic information, the data collection and analysis techniques employed, and ethical considerations.

Research Aim and Study Objectives

The principal aim of this study was to explore the lived experiences of psychotherapy clients as they navigate mandatory reporting of their childhood abuse during therapy. There were four study objectives:

- To illuminate the impact, if any, of mandatory reporting on clients' experience of the therapeutic relationship.

- To discover the influence, if any, of the mandatory reporting process on clients' experience of the therapeutic process and therapeutic outcomes.

- To uncover the perceived effects, if any, of mandatory reporting on clients' experiences of the psychotherapist.

- To explore how clients make sense of the experience and perceived impact of mandatory reporting in their broader life contexts, such as well-being, relationships, and coping.

Research Design

Choosing a Research Methodology

As outlined in the literature review, most research conducted on mandatory reporting and psychotherapy to date has been focused on psychotherapists' experiences, including their thoughts, experiences and opinions of how clients experienced the mandatory reporting of their abuse. Authors have tended to employ either quantitative or mixed-methods research designs. However, more recent studies have adopted a qualitative design. Sullivan and Forrester (2018) stated that a key limitation of quantitative research in psychological studies is that the knowledge gained from such approaches tends to reveal only a narrow aspect of what can be understood. Proponents of this approach primarily seek reliable and accurate measurements for generalisation and prediction, grounded in the principle of positivism, where the aim is to uncover objective knowledge and understand universal rules of causation (Queiros et al., 2017). Such goals are achieved through standardisation, which seeks to minimise or eliminate subjectivity from researchers and participants (Sullivan et al., 2012). Further, quantitative researchers often fail to account for meaning or how participants interpret their experiences (Wilkinson & Dokter, 2023).

As the studies undertaken to date have primarily been quantitative or mixed-method, the researcher aimed to address this imbalance by adopting a qualitative methodological approach, thus expanding the knowledge base on mandatory reporting and psychotherapy. A qualitative approach also aligned with the study's aim, which was to explore the lived experiences and meaning-making of participants. Qualitative researchers are interested in experience and

meaning, specifically “how people make sense of the world and how they experience events” (Willig, 2008, p. 8). The texture and quality of the experience are of interest, along with the meaning that people attribute to their experiences. Willig (2008) suggested that the research aim, data collection techniques, and data analysis methods cannot be mutually exclusive; they depend on each other. The quality of a qualitative study depends on the appropriateness of the data analysis method for the research aim and the suitability of the data collection method for the analysis method. To ensure that the research aim, data collection, and data analysis processes were cohesive in this study, and with a qualitative approach chosen, the next step in the selection process was to evaluate the study’s aim in relation to various qualitative research methodologies. In Table 1 below, several different qualitative methodologies are examined. The table includes a brief description of each methodology, along with an assessment of its alignment with the study’s objectives.

Table 1

Different Qualitative Methodological Approaches

	Brief Description of Methodology	Fit with the Study's Aim
Narrative Analysis	Narrative analysts focus on the story aspect of a person's attempt to understand their lives: that is, "how a person constructs a sense of self through narrative" (Sullivan et al., 2012, p. 134). The narrative or story has a beginning, middle, and end. The chronological order of the story's events should be considered.	This approach was deemed irrelevant to the research aim. This study is about how psychotherapy clients experienced and made meaning from the mandatory reporting of their abuse, not how participants created a sense of themselves through their self-narrative. Additionally, the order in which the participants shared their experiences was not important.
Discourse Analysis	Discourse analysts examine how individuals use language to construct their own reality. They assume that language cannot neutrally represent reality. Individuals' selection and choice of language shape different versions or understandings of events and phenomena. Analysts are interested in how individuals construct their experiences, objects, and phenomena using language, considering context, and how language is constructed in social situations. As discourse analysis challenges the assumption of a single reality, it can be considered a relativist / socially constructed approach (Gee, 2014).	This approach was discounted as the research aim was not to explore how participants used language to understand their experience of mandatory reporting. Langdridge (2004, p. 345) highlights the "lack of a person" within discourse analysis as analysts are primarily interested in the discourse rather than the person. This is not aligned with the research aim, which is about individuals' experiences and meaning-making.
Ethnography	The purpose of this method is to "make the strange familiar" and "render the familiar strange" (Goodley, 2001, p. 4). It is the study of social behaviours, interactions, and perceptions within groups of	This method was discounted because the primary focus of an ethnographic study is to understand people within their normal, everyday environment by observing and studying their

	Brief Description of Methodology	Fit with the Study's Aim
	people. It is a holistic approach, considering the environment, culture, and society in which people live. It involves an in-depth exploration of the meaning-making of a small number of cases (Banister et al., 2011).	behaviours, social interactions and making meaning from these observations. This approach failed to align with the study's objectives and would have posed significant ethical challenges, as the researcher would need to observe therapy sessions before, during, and after a mandatory report.
Case Study	A case study involves an intense, in-depth, and focused exploration of a singular entity, person, or event to understand it thoroughly. Yin (2018) asserts that a case is a natural occurrence with definable boundaries. These boundaries are important as they clearly define what is being studied and help maintain focus, clarity, and depth. The approach is idiographic and utilises varied sources of data, including interviews, documents, and observations. Triangulation can be used, which involves gathering additional information about the case from diverse sources, to strengthen richness, validity, and credibility (Willig, 2008).	This approach was considered for this study as it could have facilitated an in-depth understanding of the psychotherapy client's experience of mandatory reporting. However, it was eliminated because the data triangulation needed to enrich the study would have been challenging from an ethical, practical, and confidentiality perspective.
Grounded Theory	Glaser and Strauss (1967) developed this method to create theory inductively, i.e. bottom-up, meaning theory is derived from and grounded in the data. The developing theory is an attempt to understand processes and causal relationships (Galser & Strauss, 2009; Sullivan et al., 2012).	This approach was deemed unsuitable, as the aim of this study was not to develop a theory or elucidate the process of mandatory reporting during psychotherapy.

	Brief Description of Methodology	Fit with the Study's Aim
Phenomenology	This method is rooted in phenomenological philosophy and is about "the nature of experience from the viewpoint of the person experiencing the phenomenon – 'lived experience'" (Connelly, 2010, p. 127). The person is considered an 'embodied being'; thus, researchers are concerned with what it is like to live or have an experience of 'it' (the phenomenon being studied) rather than just a person's reaction to the experience (Munhall, 2007).	Phenomenology is considered the most appropriate fit for the research aim. This method's ontology (subjectivism) and epistemology (interpretivism) align with the research aim.

Within the vast array of qualitative research methods available, a phenomenological approach was selected as the best fit for the research aim, given its alignment with the study's focus on the lived experience of mandatory reporting from the perspective of the adult survivors, whose abuse is reported. As outlined above, phenomenological researchers focus on the structures of experience and consciousness as well as the lived experience. Their primary concern is to investigate and describe phenomena as individuals consciously experience them. They are not concerned with theories or explanations of causal relationships but focus solely on how individuals experience the phenomenon rather than its cause (Wilson, 2015).

The phenomenological method has two distinct approaches: descriptive and interpretative. Descriptive phenomenologists attempt to minimise interpretation and instead "focus on that which lies before one in phenomenological purity" (Husserl, 1931, p. 262). Description is primary, and interpretation is reduced through 'bracketing', where the researcher attempts to 'bracket' off everything known about the phenomenon under review and present the phenomenon as described by the participant (Thomas & Sohn, 2023). The alternative phenomenological approach is interpretive phenomenology, where no attempt is made to distinguish between description and interpretation. Instead, interpretation is seen as being intrinsically part of the description; the two cannot be separated. This draws on the philosophy of hermeneutics, where it is stated that understanding cannot occur without some assumptions being made (Dibley et al., 2020; Schmidt, 2006). Van Manen (2016, p. 181) stated that "the (phenomenological) facts of lived experience are always already meaningfully (hermeneutically) experienced. Moreover, even the fact of lived experience needs to be captured in language, and this is inevitably an interpretive process."

Although either phenomenological method would be aligned with this study's research aim, the interpretative approach, specifically IPA (Smith et al., 2022), was selected because it has roots in the domain of psychology and psychotherapy, the field of study in this research. IPA has a well-established history in qualitative healthcare research (Biggerstaf & Thompson, 2008; Harper & Thompson, 2011; Pietkewicz & Smith, 2014), which aligns with the researcher's background. This methodology provides "a detailed examination of personal lived experience. It produces an account of lived experience on its own terms … and recognises that this is an interpretative endeavour as humans are sense-making organisms" (Smith & Osborn, 2007, p. 59).

Interpretive Phenomenological Analysis

IPA is a robust qualitative research methodology that enables a comprehensive exploration of intricate and nuanced phenomena, particularly in areas where existing understanding is limited (Smith et al, 2022). Grounded in the foundational theoretical frameworks of phenomenology, idiography, and hermeneutics, IPA emphasises the subjective experiences of individuals and seeks to uncover the meanings they ascribe to their lived experiences. This methodology is "committed to the examination of how people make sense of their major life experiences" (Smith et al., 2022, p.1) and is therefore particularly effective in elucidating the complexities of human experience (Smith et al., 2022; Smith & Nizza, 2022)

Phenomenology and IPA

Phenomenology is the study of experience. Phenomenologists are concerned with exploring what it is like to be human, considering all aspects of being human, particularly the things that matter to people and shape their lived world (Smith et al., 2022). Phenomenology

began with the philosopher Husserl (1859-1938) in the 19th century, and is the study of 'phenomenon', or the appearance of things and how they appear in our experiences, the ways we experience things. In other words, the meaning things have in our experience. Phenomenology studies conscious experiences and is interested in the subjective, first-person nature of experience. (Smith, 2019). Husserl believed that if the experience of a 'phenomenon' could be studied in depth and with rigour, then the essential qualities of that experience could be known; this he called the 'essence' of the experience (Beck, 2021). These essential features or essence could transcend the particulars of their appearance and be shared with others, illuminating an essence that was common to all experiences of that phenomenon (Dibley et al., 2020). In this study, one might seek to understand the common experience of the phenomenon of mandatory reporting in therapy for clients.

Husserl (1927) discussed stepping out of our natural attitudes to everyday experiences and using a phenomenological attitude that involves a reflective turn. Rather than examining the object in the world, phenomenologists might focus on analysing their perceptions of the object (Beck, 2021). Husserl (1927) suggested 'bracketing off' or setting aside our judgements, assumptions and existing knowledge of the world to focus on our perceptions of it. This eidetic reductionism can be employed to reveal a phenomenon's essence (Neubauer et al., 2019; Smith et al., 2009; Tuffour, 2017).

Heidegger (1889/1976), a key figure in 20th-century philosophy and a student of Edmund Husserl, shifted the focus of phenomenology away from transcendental ideas towards a deeper inquiry into the nature of existence. Central to Heidegger's thought is the concept of "Dasein," or "being-in-the-world" (Heidegger, 1996, p. 50), which reflects the idea that human existence cannot be understood in isolation but is always situated within a rich web of objects,

relationships, and language. Heidegger argues that individuals are "thrown" into their contexts, suggesting that their experiences are rooted in specific circumstances and interactions. This highlights the relational aspect of existence, as Dasein is always “in relation to something” (Heidegger, 1996, p. 51). Consequently, the understanding of oneself and reality is shaped by an intricate interplay with the surrounding world, which is inherently meaningful and interconnected (van Manen, 2014; van Mann, 2016). This engagement with a world full of significance leads to further explorations of authenticity and temporality, underscoring that knowledge cannot be divorced from lived experience. The implications of Heidegger's philosophy invite a thorough examination of the ways we interpret our existence, a theme that will be further elaborated in the next section.

Merleau-Ponty (1908-1961) significantly advanced phenomenological theory, paralleling Heidegger in emphasising the interpretative and situational dimensions of human existence within the world (Smith et al., 2022). However, unlike Heidegger, Merleau-Ponty concentrated on the embodied experience of existence, advocating that "the body is no longer conceived as an object in the world but as our means to communicate with it" (Merleau-Ponty, 1989, p. 107). This perspective highlights that it is through our embodied experiences that we connect and engage with our environment, positioning our individual situated perceptions as fundamental (Beck, 2021). Merleau-Ponty posited that humans perceive themselves as distinct from objects in the world; our self-conception is holistic and actively engaged in apprehending reality rather than being entirely immersed within it (Merleau-Ponty, 1989). This bodily experience significantly influences our understanding of the world, marking a crucial element of phenomenological research, along with comprehending our emotional experiences (Willig & Stainton, 2017). Ratcliffe (2019) asserts that our emotional experiences are intimately linked to our bodily

existence and play a pivotal role in our sense-making processes, and "help us find ourselves in a world" (Ratcliffe, 2008, p.68). In IPA, Merleau-Ponty's concept of being a body-in-the-world offers vital insight into understanding a person's perspective. Given that these experiences can never be fully captured or articulated, it is crucial to pay attention to them in analysis to ensure they are not overlooked (Smith & Nizza, 2022).

Hermeneutics and IPA

Hermeneutics is the theory of interpretation, where the aim is "to make meaning intelligible" (Grondin, 1994, p. 37). Meaning can be considered ever-changing and influenced by new insights, interpretations, and revisions. Within IPA, the use of hermeneutics draws on the work of three philosophers: Heidegger, Ricoeur, and Gadamer. Ricoeur (1970) suggested that experience and interpretation are closely linked, and meaning is crucial to experience. He further argued that language and experience co-emerge; language is not merely descriptive but also expresses experience, while experience is revealed through language.

Heidegger (1962) suggested that appearance has a dual quality. Objects, events and experiences have both visible and hidden qualities, which must be brought to light through interpretation. IPA researchers believe phenomena exist that require investigation to uncover and illuminate (Tuffour, 2017).

Both Heidegger (1962) and Gadamer (2013) suggested that all understanding includes both interpretation and presumptions. Thus, IPA researchers will engage in interpretation without being fully aware of their presumptions, which are only revealed through reflection (Smith et al., 2022). This is an example of the hermeneutic circle, where a dynamic relationship exists between the parts and the whole (Schmidt, 2006). The parts can only be understood in relation to the

whole and the whole in relation to the parts. IPA also contains a double hermeneutic aspect, where two interpretative processes are used. The first involves the participant attempting to make sense of their experiences and interpreting the meaning from them. The second involves the researcher interpreting meaning from the participant's experience (Smith et al., 2022). This is evident in Appendix O, where the analysis of Rebecca's transcript is presented. Within the transcript, Rebecca derives meaning from her experiences, while in the left column, the researcher attempts to further interpret the meaning of Rebecca's experiences via the experiential statements.

Idiography and IPA

Idiography is concerned with the particular (Smith & Nizza, 2022). IPA researchers are committed to the particular at two levels, first, with their focus on a systematic and thorough analysis of the data. Second, they are concerned with how "experiential phenomena (an event, process or relationship) have been understood from the perspective of particular people in a particular context" (Smith et al., 2022, p. 29). In the case of this study, the particular is the process of mandatory reporting experienced by psychotherapy clients. Idiography contrasts with the nomothetic principles of quantitative research (as discussed above), where large groups are studied with the aim of making generalisations about research populations (Robinson, 2011). Idiographic researchers do not claim to predict behaviours but instead can make specific statements about participants, since their cases have been analysed in detail (Pietkiewicz & Smith, 2014). IPA researchers are committed to detailed analysis and take care to value each case independently before looking for convergence and divergence between cases (Tuffour, 2017).

In summary, IPA is grounded in three philosophical pillars: phenomenology, hermeneutics, and idiography. It examines how individuals interpret their lived experiences, drawing on the works of Husserl, Heidegger, and Merleau-Ponty, who highlighted the situated, embodied, and interpretative nature of experience. Central to IPA is hermeneutics, involving a "double hermeneutic" where the researcher interprets the participant's understanding of their world. Idiography further emphasises IPA's focus on in-depth analysis of individual cases rather than broad generalisation. Having considered the foundations of IPA, the focus will now shift to consider some of the criticisms and limitations of IPA.

Critique of IPA

Despite the identified alignment of IPA with the aim of this study and its popularity, especially in psychology and health research (Alase, 2017), it is not without its critics, who have criticised its philosophical grounding, methodological clarity, and analytic rigour (Willig, 2021). One issue is the recognition and inclusion of the researcher's meaning-making and interpretation within the research process, which raises concerns about whether this practice dilutes the validity of the findings from an IPA study (Cronin & Lowes, 2016). This concern is echoed by Giorgi (2010), who argued that IPA researchers misrepresent phenomenology by allowing subjective interpretation to influence their analysis without a rigorous application of epoché (the suspension or bracketing off of judgment) or reduction, which is essential for uncovering the core structures of the phenomenon being studied. Thus, it impacts the integrity of the findings in an IPA study.

Giorgi (2010) further argues that by introducing the double hermeneutic, IPA researchers risk blurring the boundary between description and interpretation, thereby losing sight of the phenomenon itself. In response, Smith et al. (2022) argued that IPA draws more from Heidegger,

Merleau-Ponty, and Sartre, for whom phenomenology is inherently interpretative rather than purely descriptive, as Husserl suggested. Therefore, IPA researchers do not bracket off interpretation but engage with it via reflexivity. Smith et al. (2022) asserted that interpretation is necessary to access the lived experience and that double hermeneutics is a necessary part of the process. Thus, in response to the criticism that interpretation dilutes the validity of the findings, Smith et al. (2022) assert the opposite: that interpretation strengthens the validity, as there is no description without interpretation.

In another strong critique, Van Manen (2017) criticised IPA for being overly procedural and reductive. He argued that the step-by-step approach, which includes making detailed notes, theme development, and interpretation, risks turning phenomenology into a technical exercise, distancing the researcher from the depth of experience and ignoring the poetic and evocative dimensions of language necessary for capturing lived meaning (van Manen, 2019). In response, Smith et al. (2022) asserted that “IPA offers a flexible and powerful analytic framework for exploring how individuals experience and make sense of key life events” (p. 4). The methodology embodies a creative and profoundly linguistic approach to qualitative research, emphasising the critical importance of language's subtleties. By meticulously examining elements such as metaphors and speech patterns, researchers can cultivate a deeper connection to the participants' lived experiences and their unique processes of meaning-making. When IPA is done well, these procedural steps become an adaptable framework, allowing for flexibility and responsiveness, rather than a rigid and prescriptive formula. This adaptability not only enhances the authenticity of the data collected but also enriches the interpretive insights derived from the analysis, ultimately leading to a more nuanced understanding of participants' perspectives (Smith et al., 2022; Zahavi, 2019).

Another significant critique of IPA relates to its focus on individual experiences and the small sample sizes it employs. Some critics argue that this approach limits the ability to generalise findings, raising questions about its relevance in areas that prioritise representativeness (Giorgi, 2010). However, supporters of IPA present a strong counterargument. Smith (2010) emphasises that the goal of IPA is not to achieve statistical generalisation but rather to enable theoretical transferability, providing rich, nuanced insights that resonate with others in comparable situations. Rather than attempting to represent an entire population, IPA seeks to explore how individuals uniquely interpret their experiences, delivering a depth of understanding often absent in larger studies. Viewed in this light, small sample sizes become a methodological asset, facilitating deeper and more meaningful engagement with the data (Smith et al., 2022).

While these scholarly debates continue, IPA is a popular methodological choice in healthcare and psychology, offering rich and in-depth insights into individual lived experiences. In the current study, IPA aligns with the aims of exploring the nuanced lived experiences of participants. It not only facilitates an in-depth investigation of individual narratives but also underscores the idiographic nature of this research study, which is essential for capturing the complexities of participants' experiences as they navigate mandatory reporting within psychotherapy. These critiques were kept in mind while conducting the current study (e.g., transparency in the audit trail of the analytic work, as demonstrated in Appendices O to R).

Researchers Reflexivity

In qualitative research, reflexivity refers to the researcher's awareness of the diverse elements they bring to the research process, including their values, beliefs, opinions, and

backgrounds, and how they critically assess how these factors may influence the research process (Creswell & Poth, 2018). Within IPA, which is deeply rooted in phenomenological and hermeneutic traditions (as explored above), there is an emphasis on the intricate interplay between researcher and participant in the meaning-making process (Smith et al., 2022). A distinguishing characteristic of IPA is the concept of the double hermeneutic: participants interpret their own experiences while researchers endeavour to make sense of these interpretations. There is an acknowledged tension present in this process, where the researcher moves back and forth, offering insights and trying to understand the data whilst putting aside their perceived ideas about the topic (Finlay, 2009).

Reflexivity empowers researchers to meticulously attend to their own influences throughout this interpretative process (Engward & Goldspink, 2020). At a theoretical level, reflexivity in IPA transcends the simple bracketing or suspension of preconceived notions; it necessitates a continuous awareness of how the researcher's fore-understandings, personal narratives, attitudes, and social identities converge with the interpretation of data (Smith et al., 2022). The insights from Heideggerian philosophy are particularly relevant here, as they underscore that preconceptions will inevitably manifest during the research process and cannot be entirely excluded. Instead, these preconceptions should be acknowledged and employed reflexively to enrich interpretation rather than to distort it (Smith et al., 2022). Reflexivity is not merely an introspective exercise but is fundamentally intersubjective in nature, aimed at elucidating the relational dynamics between participants and researchers (Berger, 2015; Jamieson et al., 2023)

Smith et al. (2009) offer helpful advice on how to incorporate reflexivity into an IPA study. This approach ensures that the participants' experiences are at the forefront while also

recognising how the researcher might influence the interpretation of those experiences. Some key strategies include seeking guidance through research supervision during the analysis phase, keeping a clear record from the original transcripts to the final experiential statements, and maintaining a reflexive journal throughout the research process, where researchers note their choices, emotional reactions, challenges, and insights at each stage of the research process, such as during interviews or when developing themes (Smith et al., 2022). The researcher of this study employed these methods to enhance the transparency and quality of the study. Key extracts from the researcher's reflexive journal are included at the end of each chapter, giving more insight into the research journey. The focus of this chapter will now transition to outlining the research methods employed in this study.

Research Methods

Participant Recruitment

Participants in this study were recruited purposively, as recommended for IPA studies by Smith et al. (2022). Purposeful sampling is a non-random form in which participants are intentionally selected based on qualities or experiences that align with the research aim (Patton, 2014). Participants were chosen for this study because they had experience of their childhood abuse disclosure being reported by their therapists during psychotherapy, under the mandatory reporting laws. Potential participants were recruited directly and indirectly. The indirect approach involved sourcing participants through psychotherapists working in private practice or for private, state-funded, or charitable organisations. Other participants were targeted directly. Recruitment was conducted through these two sources concurrently. This double-pronged

approach was designed to ensure that the opportunity to participate was offered to those who had ceased attending therapy.

Direct Recruitment

The direct recruitment approach aimed to facilitate participation from individuals who had engaged in psychotherapy in the past, had left therapy, or were attending psychotherapy for a reason other than childhood abuse, but had experience of mandatory reporting with different therapists, or those whose therapists had been targeted through the indirect recruitment but did not discuss the study with them. Below are the approaches undertaken for direct recruitment.

- The researcher developed a website for the study. This involved creating a Google Site containing the researcher's recruitment flyer, video, information sheet, and contact details (see Appendices C to F).
- Due to the sensitivity of the research topic, the researcher made a recruitment video outlining the study's objectives. This offered potential participants the opportunity to see and hear the researcher before deciding to make contact (see Appendix E).
- The recruitment advertisement was included on publicly available websites that advertise research participation opportunities to the public. While Volunteer.ie could not accommodate the study because the account had to be held by an organisation, not an individual, the advert was active on Activelink.ie for six months.
- Private practices and charities offering general psychotherapy were contacted via publicly available contact details. These organisations were invited to place the recruitment advertisement in their waiting rooms (both physical and virtual), thereby

bringing the study to the attention of their clients. More than 30 emails were sent, but no responses were received, so it is not known whether any organisations promoted the study.

- The organisers of Aware, Grow, and Shine—support groups for people who have experienced childhood trauma or mental health issues—were contacted via publicly available contact details and asked to display the recruitment poster at their meetings. Shine and Aware replied to say that, unfortunately, they could not support the study because they did not consider it a good fit with their service users. No response was received from Grow.

Indirect Recruitment

- The study details were sent to all counselling, psychotherapy, and psychology bodies and institutes in Ireland (Irish Association for Counselling and Psychotherapy (IACP), Irish Association of Humanistic and Integrative Psychotherapy (IAHIP), Psychological Society of Ireland (PSI), National Association for Professional Counselling and Psychotherapy (NAPCP), Irish Council for Psychotherapy (ICP), and Association for Psychoanalysis and Psychotherapy in Ireland (APPI)), requesting that the study be advertised in their newsletters, weekly updates, and research updates. The study was advertised in the members' areas of IACP and IAHIP, but no response was received from the other organisations.
- The websites of the organisations detailed above were used to identify psychotherapists working in the area of trauma and childhood abuse. The psychotherapists were contacted via their publicly available email addresses. They were sent the invitation email together

with the recruitment advertisement. More than 600 therapists were contacted via email. Various responses were received, with some therapists stating that they could not accommodate the study, while others had no current clients for whom mandatory reports had been made. Fifteen said that they would discuss the study with their clients. No other communication was received from these therapists.

- The researcher contacted the following organisations, which specialise in providing counselling and psychotherapy to adult survivors of childhood abuse. In all cases, this was done via publicly available contact details. The organisations were invited to share the study details with their therapists and clients.
    - HSE's National Counselling Service: Advertised the study in their waiting rooms and stated their therapists would discuss the study with their clients.
    - One in Four: Advertised the study on their social media and newsletter and stated that their therapists would bring the study to the attention of their clients.
    - Rape Crisis Network: No response received.
    - Connect Counselling: No response received.
    - Towards Healing: No response received.
- The researcher offered to meet with staff groups (in person or by Zoom) to give information about the study. No organisation took up this offer.

At the conclusion of the recruitment process, it was observed that 20% of the participants were acquired through direct recruitment methods, while a significant 80% were sourced through indirect recruitment strategies. Notably, of this 80%, approximately 50% of participants became aware of the study through advertisements disseminated on One In Four's Instagram account.

Detailed information regarding the channels through which each participant was informed about the study can be located in Appendix K.

Opening and Closing of Recruitment

The recruitment process spanned seven months, from November 2022 to May 2023. Participants who met the inclusion criteria (see below) were invited to participate in a semi-structured interview. Once the target number of participants had been reached and interviewed, recruitment was closed. At this point, all study advertisements were withdrawn. Emails were sent to all organisations involved in the indirect recruitment informing them that recruitment was now closed, requesting that they remove the advertising posters, and thanking them for their support. After this point, three potential participants contacted the researcher but were informed via telephone or email that recruitment was closed. They were thanked for their interest.

Participants

No conditions, about the number of reported cases of abuse or the type of abuse, were placed on the disclosure or reporting of childhood abuse. Therefore, participants could have disclosed their abuse in therapy for the first time or on different occasions with different therapists. Each disclosure to each therapist would require a report to be made (as discussed in the literature review). As the topic of the study is the mandatory reporting of childhood abuse, and it is the therapist who is mandated, it was a requirement of the study that the therapist had made the report and not the client themselves.

As discussed above, participants in this study were selected purposively. As noted by Creswell and Creswell (2022), participants in an IPA study must share lived experiences relevant

to the phenomenon under investigation, resulting in a homogeneous group of participants. To achieve this, a predetermined set of criteria was established, meaning that certain cases were included or excluded based on specific standards (Patton, 2014). The inclusion criteria were as follows:

Inclusion criteria:

- Over 18 years of age.
- Any gender.
- Any geographical location in Ireland.
- Has attended psychotherapy as an adult.
- Has self-disclosed childhood abuse during psychotherapy, which resulted in a mandated report being made to Tusla.
- Fluent in English.

Exclusion criteria:

- Any current or past client or student of the researcher.

Of the 10 participants in the study, seven were women, and three were men. Six attended counselling in a specialised counselling service, and nine received one-to-one therapy. One participant attended group therapy. All participants experienced child sexual abuse. Table 2 below contains the demographic details of the participants, along with their history of counselling, and details of the type of childhood abuse they experienced. Appendix L contains additional details about the mandatory reports. Details of the participants' knowledge, awareness and experience of mandatory reporting prior to attending therapy are detailed in Appendix M.

Table 2

Participants' Demographics and Additional Information

Participant [1]	Gender and Age	Type and Place of Counselling where M.R. was Made	History of Counselling	Type of Childhood Abuse
Sophia	Female, 40's	One-to-one counselling in a specialist organisation[2]	1st time in therapy	Family member – sexual abuse
Ben	Male, 70's	One-to-one with a therapist in private practice	26 yrs in and out of therapy due to childhood abuse	Sexual abuse – Perpetrator deceased
James	Male, 50's	One-to-one counselling in a specialist organisation	1st time in therapy	Family member – all four types of abuse
Inka	Female, 40's	One-to-one counselling in a specialist organisation	1st time in therapy	Sexual abuse - family
Rebecca	Female, 30's	One-to-one counselling in a specialist organisation	Attended once previously – unrelated to abuse, abuse not discussed	Sexual and emotional abuse – relationship with abuser not given
Helen	Female, 60's	One-to-one counselling in a specialist organisation	Yes, attended once previously – unrelated to childhood abuse, abuse not discussed	Sexual abuse - Family members – multiple abusers
Anne	Female, 40's	One-to-one with a therapist in private practice and as an inpatient in a psychiatric hospital.	Attended counselling in college – unrelated to the abuse. Abuse not disclosed	Sexual abuse – family
Grace	Female, 50's	One-to-one counselling in a specialist organisation	Yes, in the USA previously, abuse was discussed but not reported.	Sexual abuse – family
Alma	Female, 30's	One-to-one with a therapist in private practice	Yes, both as an adolescent and an adult – no disclosure. The therapist asked, but Alma denied any abuse.	Sexual abuse - family
Ivan	Male, 60's	Group therapy during an inpatient stay in a psychiatric hospital	Unknown, in MH services 30 yrs	Sexual & physical abuse - institutional/clerical

1 Pseudonyms have been used to protect participants' identities.

[2] Specialist organisation refers to state-funded organisations which offer counselling to survivors of abuse. These include Rape Crisis Centres – nationally, One-in-Four, National Counselling Service and Towards Healing

Data Collection

Aligned with IPA's phenomenological foundation, the researcher encouraged participants to provide rich, detailed, first-person narrative data about their experiences (Smith et al., 2022). Participants could choose between an in-person or a Zoom interview; five participants chose the in-person option while five chose Zoom, primarily due to geographical location. Both choices enabled participants to share their experiences of mandatory reporting, as well as their stories, thoughts, and feelings. See Appendix L for details on the interview format and duration. Consistent with IPA methodology, a semi-structured interview format was employed, which allowed participants the space to speak freely and reflect on the discussions. This format facilitated the emergence of new insights (Smith et al., 2022).

The interview questions were phrased openly and expansively, transitioning from descriptive to analytical. The questions were short and focused on broad topics, allowing the participant to determine the parameters of the discussion without the researcher imposing her narrative through direct questioning (Hefferon & Gil-Rodriguez, 2011). Smith et al. (2009) suggest using six to 10 open-ended questions in a 90-minute interview. Furthermore, the structure allowed the researcher to adjust the interview schedule, modifying questions and probes in response to the participant's account. Real-time interactions between the researcher and participants enabled instant and natural responses to their narratives, facilitating a deeper exploration of their experiences (Sullivan & Forrester, 2018). The first question asked was intended to elicit a descriptive account, helping participants feel comfortable sharing their stories. This approach also facilitated rapport-building, as the researcher listened attentively and empathically (Smith et al., 2022). Once rapport was established, the researcher gently guided the participant into a more analytical space, encouraging a fuller exploration of the lived experience

and its importance. This strategy was applied throughout the study, as detailed in the interview schedule (see Appendix I). Each interview commenced with the open-ended question: “Tell me about your experience with mandatory reporting in therapy”, allowing the participants to choose where they began telling their story. The questions on the interview schedule were covered during the interview. Flexibility about the order was used to follow the participants' narrative.

When preparing for and conducting an IPA interview, the aim is to “come at the research question sideways” (Smith et al., 2022, p. 63). Research questions can be abstract, making it difficult for participants to answer them directly. To overcome this, one aspect of interviewing for an IPA study is to discuss topics related to the research question from a different perspective. An example of this can be seen in Rebecca’s interview extract (see Appendix O), where she discussed her obligation to protect others. Although this was not asked directly, it was a core aspect of retrospective reporting of child abuse across the study. Once Rebecca had raised this, the researcher prompted her to elaborate on her experiences, thus “coming at it sideways”.

The in-person interviews were audio-recorded on the researcher’s iPhone; a second iPhone was used to record interviews in case of any technical issues. The Zoom interviews were recorded on the researcher’s laptop and, as a backup, on her iPhone. In accordance with IPA, the researcher required the interview recordings to be transcribed verbatim, as these would serve as the data for the study. The researcher transcribed each interview herself after it was conducted. Express Scribe software (a transcription audio player which allows easy typing with the use of a foot pedal and variable speed playback) and Microsoft Word were used to transcribe the interviews verbatim. A verbatim transcription of the words spoken by everyone during each interview was conducted. Other essential aspects of the interview, such as hesitations, non-verbal communication, and pauses, were captured in the transcripts in bracketed notation.

Data Analysis

In IPA, there is no stipulated single method of data analysis (Smith & Nizza, 2022). However, the analytic focus is common to all IPA studies, directing the researcher to focus on how participants make sense of their experiences. Processes and principles inform IPA analysis (Smith, 2011). These processes include "moving from the particular to the shared, and from the descriptive to the interpretative" (Smith et al., 2022, p. 79). The principles include the researcher's obligation to understand the participants' lived experiences and meaning-making. Conducting interpretative phenomenological analysis has been described as an inductive and iterative cycle, in which the researcher retraces their steps, moving in a cycle between description, interpretation, and reflection. This process is continuous throughout the data analysis (Pietkiewicz & Smith, 2014).

In keeping with the idiographic foundation of IPA, the researcher thoroughly analysed the first case before moving on to the next. Steps one to five (outlined below) were methodically executed for each case before advancing to the next.

Step One – Reading and Re-reading

In the first data analysis stage, the researcher 'immersed' herself in the data to ensure that the participant, their voice, and their story become the focus of the analysis (Smith et al., 2022). Immersion involved reading and re-reading the transcripts to become familiar with the data. Before reading the transcript, the researcher listened to the audio recording twice. The first time was to refresh her memory about the interview, the participant's voice and overall story, and to become immersed in their words and experience. The purpose of the second listening was to observe any changes or notable aspects of the participant's vocal inflection. The analysis of

Rebecca's transcript, in Appendix O, shows initial notes and thoughts about this aspect recorded in black in the right-hand column. These notes laid the foundation for the linguistic comments in step two (see below). The researcher then read the transcript. Smith et al. (2022) recommend slowing the analytic process down here, giving the researcher time to record their feelings and thoughts about the data in their reflexive journal. This process of reflection (as discussed above) helped the researcher to bracket some of her thoughts, observations, preconceptions, and presuppositions, thereby gaining a closer understanding of the data.

Step Two – Exploratory Noting

This stage of the analysis is considered the most time-consuming and detailed, which was the case in this study. The researcher should approach this stage with a focused and inquisitive mindset, paying meticulous attention to the text and its contents. Smith et al. (2022) suggest capturing exploratory notes in a document with the original transcript. Transcripts in this study had three columns: the original verbatim transcript in the centre, the left column for experiential statements (see step three, below), and the right column for the exploratory notes created in this step. This structure helped the researcher stay close to the original data, keeping the participant at the centre of the analysis. It also facilitated a transparent audit trail from the original data to the exploratory notes, thus enhancing the study's validity (see Chapter Six) and addressing one of the criticisms of IPA, discussed above. This structure was strictly adhered to for all 10 transcripts. Files were created in Microsoft Word, utilising the Tables function. The extract from Rebecca's analysis (see Appendix O) demonstrates this format, with the original transcript in the centre and the exploratory notes in the right-hand column.

In IPA, there are no set rules regarding which part of the transcript to comment on; this is at the researcher's discretion (Smith et al., 2022). However, in the original version of IPA (Smith et al., 2009), three types of comments were suggested for consideration: descriptive, linguistic, and conceptual. That format was utilised in this study. Sullivan and Forrester (2018, p. 192) advise that, at this stage of the analysis, these comments should be taken at face value, saying: "it is important not to get carried away with ideas about what could be implied from what is said, that comes later". At this early stage of the analysis, the descriptive, linguistic, and conceptual comments that came to the researcher were noted, considered, and reflected upon, but not to any great extent, as this will be addressed in later stages of the analysis. At this stage, the purpose is to note these initial thoughts and ideas. The researcher found that this became easier with each transcript she worked through. The challenge initially was getting caught in what Sullivan and Forrester (2018) warned about, 'getting carried away', going in too deeply at this early stage without having an appreciation for the 'whole'. With time and practice, this flow of going with, or trusting the initial thoughts and feelings, came more easily.

Descriptive comments remain close to the participant's explicit meaning and have a phenomenological focus, describing the content while noting aspects and meanings that are important to the participant. These are in yellow on Rebecca's extract (Appendix O). Linguistic comments analyse the language used, unpacking striking words, observing repetition, considering the use / or switching of pronouns, and looking for hidden meanings in how the participant uses language. Any metaphors were commented on. These comments are in pink in Appendix O. Any reference made by the participants to their body was noted too (see above for importance). Finally, conceptual comments are more interpretive. These shifted the focus to the researcher's conceptual understanding of the participants' experience of mandatory reporting

during therapy. These are in orange in Rebecca's extract. Smith et al. (2022) state that the researcher will draw on their professional and personal experiences during this initial conceptual noting. This was the case in this study; the researcher captured these reflections and discussions with her supervisors in her reflexive journal.

Step Three – Constructing Experiential Statements

This stage was built on the work conducted in stages one and two above. The original transcript and initial and exploratory notes were used as the building blocks for this stage of the analysis to construct the experiential statements. The challenge here was to reduce the amount of data (transcript and notes) while still maintaining the complexity of the interrelatedness between the notes and the original transcript. Therefore, the analysis shifted focus towards working with the notes whilst still holding the transcript in mind. The goal was to construct statements that captured the experiential essence; thus, experiential statements. The hermeneutic circle informed this process, where the parts were interpreted in relation to the whole and the whole is interpreted in relation to the parts. Creating experiential statements involved focusing, at the 'part level', on distinct sections of the transcript and, at the 'whole level', applying what was learned from the note creation to the whole transcript. Experiential statements "are usually expressed as phrases which speak to the psychological essence of the piece and contain enough particularity to be grounded but enough abstraction to be conceptual" (Smith et al., 2022, p. 87). The experiential statement can contain both the participant's original words and the researchers' interpretation, leading to a "synergy between description and interpretation" (Smith et al., 2022, p. 90).

Rebecca's experiential statements can be seen in Appendix O. They are noted in the left-hand column. At the end of this stage, the analysis document included the experiential statements in the chronological order in which they appeared in the transcript.

Step Four – Searching for Connections Across Experiential Statements

In this step, researchers take the chronological experiential statements from step three and find a way to fit them together. Smith et al. (2022) suggest searching for connections across statements by typing up all of the experiential statements, printing them and then cutting them up, so that each experiential statement is on a separate piece of paper (See Appendix P). Then, mixing them up so they are not in chronological order, placing them on a large surface, and grouping them based on similarities or differences, convergence and divergence. The aim of this process was to develop personal experiential themes (PETs) which represent patterns, connections, and differences in the experiential statements. This stage of the analysis is informed by double hermeneutics, where the researcher makes meaning from the participants' meaning-making, as outlined above. The techniques used to organise the PETs included abstraction, subsumption, contextualisation, numeration, and function. Abstraction and subsumption, work together to organise ideas into themes and to build thematic hierarchies, providing a structured framework for understanding. Contextualisation describes how experiences are embedded in the life context. Numeration serves as a method for assessing significance, noting the frequency or emphasis of themes, and function emphasises understanding the purpose or action of (Smith et al., 2022; Smith, 2024)

The researcher followed these steps. Her process is outlined in Appendix P (steps one to five), which illustrates the different stages of developing the PETs for Ben.

Step Five – Naming and Organising Personal Experiential Themes (PETs) into a Table

The aim of this step was to organise the experiential statements into clusters. These clusters become the PETs (see step 6 in Appendix P). Smith et al. (2022) explain that these PETs are personal because they relate to the participant, experiential because they relate to the participant's lived experience or sense-making and, finally, thematic because they relate to analytic entities presented in the whole transcript rather than specific instances. Once the experiential statements were clustered into themes (see step 5 in Appendix P), the researcher examined these themes for sub-themes. Following Smith et al. (2022), four main organising concepts were used. Firstly, looking for similarities across the experiential statements, and grouping them based on similar, related experiences. Secondly is polarisation, which is the opposite of similarity, and where experiential statements are grouped together because they are conflicting or contrasting. Grouping them this way highlights the complexity of the experience. Third is grouping based on narrative, here, by bringing statements together demonstrates an unfolding set of events, and finally, grouping the experiential statements based on function. Direct quotes from the transcript were placed alongside each subtheme. This strengthened the audit trail of the study, transparently identifying which sections of the transcript the experiential statements, sub-themes, and PETs were derived from. The quotes selected for the table were ones that offered the richest account of the participants' lived experience and were used to inform the write-up of the findings in Chapter Five.

The final stage in this step was to create a table for the participant that demonstrated the PETs, sub-themes, and transcript extracts supporting these sub-themes. Appendix P includes an extract from Ben's table of PETs, demonstrating the link between the PET, experiential statements, and transcript extracts.

Step Six – Continuing the Individual Analysis of Other Cases

This step involved repeating the steps outlined above for the next participant's transcript. The analytical process was undertaken for all 10 cases in the study. In keeping with the idiographic method of IPA, the researcher had to approach each case in its own right, giving each participant's lived experience the same respect as the first case and allowing unique themes to emerge. The research process was continually informed by this 'bottom-up' approach (Smith et al., 2022). The researcher endeavoured to bracket off any ideas from the first or subsequent cases, because in hermeneutic terms, these previous ideas could influence the interpretation of the new cases; in other words, the fore-structures (the current case being analysed) would be altered by the knowledge gained in the previous cases (Smith & Nizza, 2022). The researcher used her reflective journal to write a debrief after each case; this helped her free herself of the ideas of each case before moving on to another. She also found that when links between cases became apparent, she would note them in the journal. This technique of writing down and reflecting helped her let the ideas go, which freed her up to consider the current case.

Step Seven – Developing Group Experiential Themes Across Cases

The final stage of the analysis involved examining all cases to identify patterns, divergence, and convergence. The PETs of each case were compared. Themes were combined or

renamed where appropriate to create the group experiential themes (GETs). The researcher attempted to create the GETs in the same way as the PETs, printing out all of the PETs and then cutting them into separate pieces of paper, before trying to cluster them into themes (see Appendix Q). However, it soon became apparent that this approach would not work as there were too many PETs across all 10 cases. Instead, the researcher opted to use Microsoft Excel to group the PETs based on similarity (in the same Excel sheet) and difference (in different Excel sheets), within a single Excel workbook. This approach, which is illustrated in Appendix Q, helped manage the vast amount of data to be organised.

The result was a master table of themes for the group, in which the GETs and their corresponding PETs were detailed, along with relevant verbatim quotes. An example of this can be seen in Appendix R. This return from the whole (GETs) to the transcripts (PETs) is another example of the hermeneutic circle.

Ethical Considerations

Ethical approval for this study was granted by the Dublin City University (DCU) Ethics Committee on 13th August 2021 (see Appendix A). Specialist organisations, including One in Four and the National Counselling Service, were approached to promote the study to their clients. While these organisations did not require separate ethics approval, they requested documentation and the DCU ethical approval for review by their Boards. Both organisations' Boards agreed to support the study.

During the ethical approval process, potential concerns were addressed, and protective measures were integrated into the study design. Adhering to the "ethics as process" model (Ramcharan & Cutcliffe, 2001), the study embraced ongoing ethical reflection to address

unforeseen dilemmas throughout its duration. This study adhered to key ethical principles: non-maleficence, justice, respect for autonomy, and beneficence (Beauchamp & Childress, 2019). These principles guided the researcher throughout the investigation, prioritising ethical considerations and safeguarding the rights and well-being of all those involved in the study. A closer examination of each principle will follow.

Non-Maleficence

The principle of non-maleficence emphasises the obligation to avoid causing harm (Beauchamp & Childress, 2019). In this study, protecting participants' identities and confidentiality was paramount. Measures included secure storage of data on encrypted, password-protected systems to minimise risks of unauthorised access. Participants were anonymised using pseudonyms, and any identifiable information was removed from the transcripts. Contact details were kept separate from the data and were accessible only to the researcher. Participants were informed prior to the interview that the researcher could not offer complete anonymity due to the use of verbatim accounts for the study's findings.

Given the sensitive nature of the research topic and the potential vulnerabilities associated with participants' experiences of childhood abuse and psychotherapy, it was important that participants had access to detailed information about the study and the implications of participation prior to making contact. A research video was also recorded to give the participants an introduction to the researcher. It was hoped that this approach would allow participants to consider their involvement before expressing their interest in the study, which implicitly also necessitated disclosing their abuse and therapy history. All participants reported accessing the information and watching the video before initiating contact.

Participants were invited to select their own pseudonyms. It was hoped that this would be seen as a way of respecting their contribution and empowering participants to, in a small way, have a sense of empowerment over their experiences, and to help break the pattern of 'silencing' that comes with childhood abuse (Sanderson, 2006). All participants, except for Ben, chose their own pseudonyms, and for many, this choice held significant meaning for them.

While the research was not directly about participants' experiences of childhood abuse, it was recognised that participants might discuss such experiences during the interviews. As this might elicit distress, the research protocol included measures to mitigate any adverse effects. For example, prior to the interviews, participants were reminded of their right to terminate the interview or take a break at any point should they feel uncomfortable. Furthermore, the researcher, a qualified counselling psychologist with extensive experience in supporting individuals in distressing situations, maintained an ongoing assessment of participants' emotional well-being throughout the interviews. This proactive approach included regular check-ins to ensure that participants felt safe and supported. Although some participants discussed aspects of their abuse history, no one became distressed enough to need a break or end the interview. However, many required some form of intervention from the researcher during the interview, such as "let's take a moment".

It was also acknowledged that participating in the study might evoke strong feelings in participants after the interview concluded and that, in some instances, they may lack access to support resources. Therefore, a debriefing sheet was created (Appendix J), which provided information about support organisations. All participants received this sheet after their interview, following a short de-brief with the researcher. The study also provided additional support, in the form of counselling, which could be made available to participants, should they require a more

extensive de-brief around issues raised by the interview. A maximum of two sessions was allocated to each participant, if required. DCU's counselling service (Healthy Living Centre) would provide the counselling, and it would be funded equally by the University (refer to Appendix B) and the researcher. No participants needed to avail of this additional support.

As a mandated reporter, the researcher had a responsibility to report any undisclosed incidents of childhood abuse that might have arisen during interviews. Participants were made aware of this via the information sheet, the informed consent form, verbally at the point of initial contact, and again before the interview commenced. There were no new disclosures of any current or historic abuse in the interviews.

The researcher benefited from continuous support throughout the research process, facilitated by her research supervisors. In addition, if necessary, she had access to further pastoral care from an Independent Panel member. During the interview phase, provisions were established to ensure that the researcher received timely support to address any challenges that arose from the interviews. It was agreed that the researcher could contact either supervisor by telephone following the interviews. The interview process did not raise any immediate issues for the researcher, and she did not need to avail of this additional support.

Justice

Justice in research ethics involves ensuring equitable and unbiased conduct in studies (Beauchamp & Childress, 2019). The researcher prioritised this principle by widely advertising the study to make it accessible to all interested participants who met the criteria. A direct recruitment strategy was employed to reach individuals not currently attending psychotherapy, thereby minimising the risk of excluding certain individuals based on their circumstances. Justice

was also addressed in the findings to ensure all participants' experiences were equally represented, without privileging any individual's perspective.

Respect for Autonomy

Respect for autonomy highlights the need to acknowledge an individual's right to make informed decisions (Beauchamp & Childress, 2019). This requires providing clear and accessible information about the study (Hammersley, 2014). To enhance informed consent, the researcher created a dedicated website with all relevant documentation, with the web address and QR code included on the recruitment flyer (see Appendix C), allowing participants to access the information at their convenience and independently.

During the initial phone consultation, the researcher discussed potential participants' motivations to ensure no undue pressure was applied. After this phone call, participants were offered time to consider their involvement before committing to the study. Prior to the interviews, participants were asked to provide formal consent by completing the consent form and were informed they could withdraw at any time without needing to provide an explanation.

Beneficence

Beneficence can be defined as “to act for another’s benefit” (Beauchamps, 2016, p.6) and, in terms of this research study, concerns any benefits that participants may have gained from participating in the study. Although there are no direct or immediate benefits to participating in the study, participants may still benefit indirectly. According to Legerski & Bunnell (2010), participants who volunteer for trauma-focused research self-appraise their participation as positive, rewarding, and beneficial to society. In this study, indirect benefits may include being positively impacted. Participation in this study provided adult survivors with an opportunity to

share their own lived experiences and have them heard and documented. Secondly, although the study was not designed to be therapeutic and the researcher explicitly explained that there was no psychotherapeutic aspect to the study, it was conducted in a trauma-informed, empathic and sensitive manner, which may have had a positive impact on participants.

Finally, by being involved in the study, participants may provide benefits to the broader community, namely, adult survivors who are trying to navigate mandatory reporting, and the clinicians from whom they seek help and support, also mandated reporters in other professions, along with policymakers and stakeholders.

Conclusion

This chapter examined the study's objectives and methodological approach, focusing on the rationale for choosing Interpretative Phenomenological Analysis (IPA) and its suitability compared to other methods. The philosophical foundations of IPA, including phenomenology, hermeneutics, and idiography, were discussed in detail, along with an exploration of some of the criticisms levelled at IPA and the rebuttals offered by Smith et al. (2022). An outline of the participant selection and recruitment processes, along with the data collection and analysis methods utilised in the study, was discussed. Lastly, the ethical considerations of the study were discussed, highlighting the study’s commitment to integrity, safety, and respect for participants.

Researcher's Reflexive Comments

When learning about the different research methodologies in preparation for this study, I was drawn to the phenomenological approach, perhaps because it aligned most closely with my theoretical orientation as a person-centred counselling psychologist. Initially, I opted for Giorgi's descriptive phenomenology, mainly because I believed this method would stay as close as possible to the participants' experiences, which was one of my aims for the study. However, as I read and learnt more about the different methods, I became interested in the ideas of meaning-making (that is, how human beings make sense of their experiences) and hermeneutics (how we, as human beings, interpret the world), which introduced me to IPA. This again aligned with my personal experiences as a counselling psychologist who has worked with clients who struggle to understand and interpret their experiences.

Implementing IPA was much more complex, nuanced, and time-consuming than I had anticipated. I attended two online training programs with Jonathan Smith and thought I was well-prepared. However, like everything, the devil is in the detail. I struggled to balance my desire to privilege the participants' idiosyncratic stance with hundreds of pages of transcripts to note and analyse. I enjoyed the noting and found, as I went on, that this was the most enjoyable aspect for me, perhaps because I was simply commenting on what I read and noticed. When I encountered experiential statements, PETs, and GETs, I tied myself in knots trying to stay close to the participants' experience and worrying that my interpretations were incorrect. On reflection, I believe this was the most significant lesson I learned from this stage of the research process: that the hermeneutic circle can make the process longer and more complex, rather than simplifying it.

Another significant learning experience occurred during the recruitment stage. Ever since I conceived of the idea for this study, the feedback I received was that it was a great idea, but how would I get people to discuss something so emotive? As such, there was always a worry about finding participants for the study. When discussing direct recruitment with my supervisors, one suggested making a video. My initial response was "no way". I am a very private person; I do not have a social media presence, and the thought of creating a video and posting it online was way outside my comfort zone. But the idea lingered, as I thought about what I was asking of the participants—to share their personal experiences about such a sensitive topic—when I could not, or would not, step out of my comfort zone to meet them. Once I had this realisation, I went about learning how to make a video, and my online debut took place (see Appendix E). In the end, the recruitment was not as difficult as everyone thought. However, that was largely due to One in Four adding a research section (which included the study) to their Socials midway through the recruitment stage. Interestingly, four participants followed One in Four's Instagram and saw the study. The most surprising aspect of recruitment for me was that the majority (80%) came directly, only two participants came via psychotherapists - it made me wonder who doesn't want to talk about mandatory reporting? The clients or the therapists?

Chapter 4

Findings Chapter

"... and the day came when the risk to remain tight in a bud
was more painful than the risk it took to blossom."

Anais Nin (n.d.)

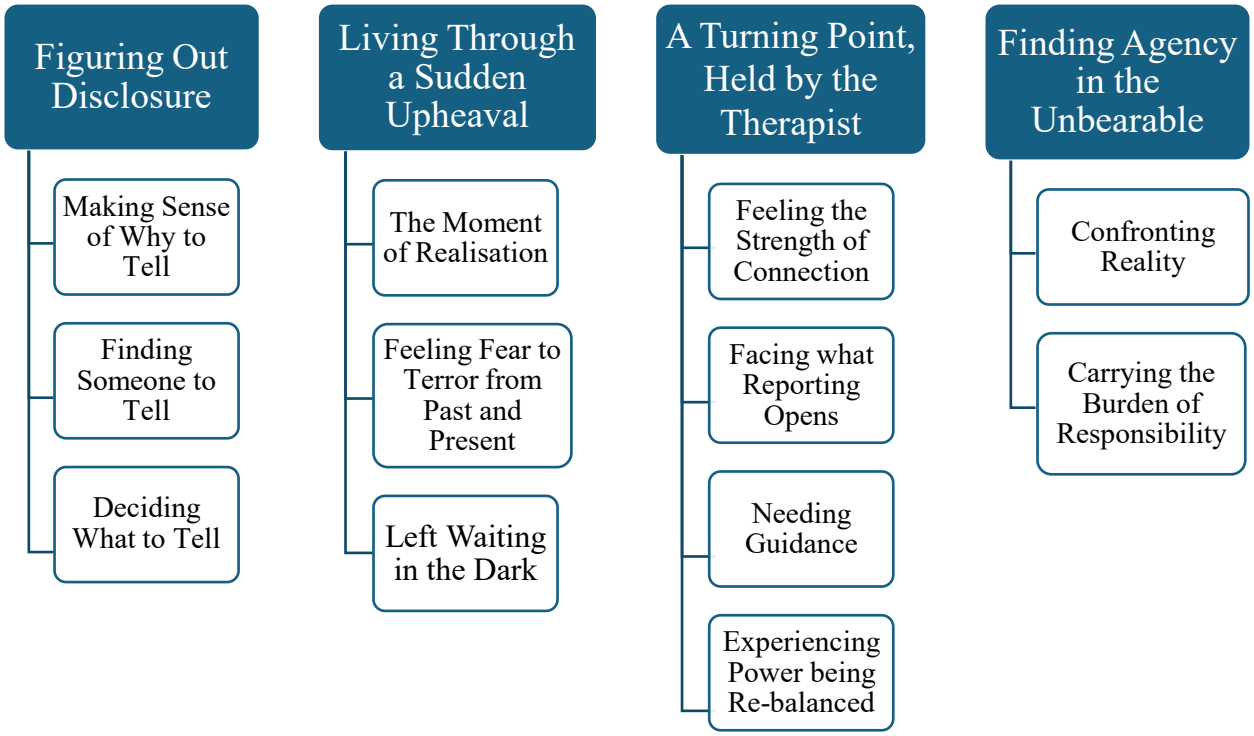
Introduction

The key findings from this study of how adult survivors of childhood abuse experienced the mandatory reporting of their abuse during psychotherapy are presented in this chapter. These findings were derived from an in-depth interpretative phenomenological analysis (IPA) of transcripts from 10 semi-structured interviews. Four group experiential themes (GETs) and 12 sub-themes were identified and are illustrated in Figure 1. This chapter is structured to explore each GET and its associated sub-themes, concluding with a summary.

The four distinct and interconnected GETs emerged from the data analysis, titled *'Figuring out Disclosure', 'Living Through a Sudden Upheaval', 'A Turning Point, Held by the Therapist',* and *'Finding Agency in the Unbearable'.* Each GET encapsulates a specific lived experience regarding mandatory reporting during psychotherapy. Sub-themes elaborate on the meanings participants attributed to their experiences.

Figure 1

Table of Group Experiential Themes



The first GET, titled *'Figuring Out Disclosure'*, is about the considerations and decision-making processes that participants faced regarding their experiences of abuse, both before entering therapy and during the early phases of their therapeutic journey. Their level of understanding of mandatory reporting laws, as well as their previous therapy experiences, influenced this process. The second GET, *'Living Through a Sudden Upheaval'*, illustrates the immediate, unexpected, embodied response participants had upon being informed by their therapist that their abuse needed to be reported to Tusla under the mandatory reporting laws of that time (these laws changed twice during the data collection stage of the study, as outlined in Chapter 2). As the participants began to process the reporting of their abuse, a rising wave of fear rooted in both past and present emerged, along with a period of waiting alone in darkness

without clarity or control. The third GET, *'A Turning Point, Held by the Therapist'*, details a crossroads in therapy, marked by the process of mandatory reporting, when participants either re-experienced past traumas or found healing and transformation from their earlier traumas, both of which unfolded within the context of the therapeutic relationship. The therapist played a vital role in influencing participants' direction and experience during this crucial juncture. In the fourth and final GET, '*Finding Agency in the Unbearable'*, participants shared some of the challenges they faced with mandatory reporting during their therapy. By navigating these obstacles, they reclaimed a sense of agency, which their abuse experiences had impacted.

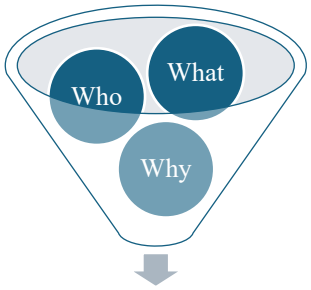
Each GET and its corresponding sub-themes will now be presented and analysed, see Appendix T for the prevalence table showing the number of participants per sub-theme. Verbatim extracts from the participants' interviews will be used to illustrate their experiences and support the findings. All transcript extracts are presented in italics.

GET 1 – Figuring Out Disclosure

In the first GET, *'Figuring Out Disclosure'*, the processes, meaning-making, decisions, and considerations each participant needed to navigate regarding whether or not to reveal their abuse experience, either before attending therapy or in the early stages, are highlighted. Each participant, to differing degrees, actively thought about how they might disclose their abuse in therapy. Figure 2 illustrates the various sub-themes identified in the analysis. The first sub-theme, *'Making Sense of Why to Tell'*, covers participants' inner process of understanding and making sense of their reasons for seeking therapy at this time, and how their current therapy experiences differ from previous ones. The second sub-theme, *'Finding Someone to Tell',* illustrates how participants found their therapist, a process that involved careful consideration,

built on previous experiences, and extensive research for some. Others had less choice. The final sub-theme, *'Choosing What to Tell',* covers participants' choices about who and what they were willing to share with their therapists and how this was influenced by their existing understanding and knowledge of mandatory reporting requirements and laws (see Appendix M for details of participants' knowledge of mandatory reporting).

Figure 2
GET 1 – Figuring Out Disclosure



Figuring Out Disclosure

Sub-Theme 1 – 'Making Sense of Why to Tell'

The first sub-theme, *'Making Sense of Why to Tell*', covers participants' experiences of trying to understand why they would disclose their childhood abuse experience and the reasons for seeking support for their abuse. Participants discussed the events and experiences that led to them seeking support via psychotherapy at that time, and how they make sense of this within their life context. All participants reported that it was not their childhood abuse per se that prompted them to seek therapy, but their long struggle with trying to live with the impact of that experience on their day-to-day lives. For Anne, who was in her 40s and had no knowledge of mandatory reporting before therapy, these struggles involved living with an eating disorder for over 20 years. As for all participants, there was a decisive moment in this struggle when the impact on her daily life became too much to bear. Anne said:

> *I had never talked about it to anyone …. I had got to a stage where that it was really, really impacting my life, and I was like, I can't go on like this. I just got to a stage where I was like, I can't do this anymore. (A, p. 1)*

Anne's repetition of the word *"really"* emphasised the impact of her eating disorder on her life. Her use of the word *"stage"* suggests that there were different levels on her journey with her eating disorder. This was a long, ongoing battle that was not getting any easier for Anne; indeed, she felt that she could no longer continue. Reaching this point was the trigger for her to explore engaging in psychotherapy.

It was similar for Helen, who shared; "*I had been struggling particularly for the last four years … my life was imploding … I had run out of support strategies to manage my own life" (H, p. 7)*. Time and being alone were important factors here; both Anne and Helen reported years of trying to manage their symptoms alone, leaving them depleted and unable to continue, prompting them to find help and support. There was also a sense of needing to be *"broken down enough" (Ben, p. 25)* before help was sought.

This inability to continue was more extreme for Inka and Ben, as both had reached a point where they no longer wanted to live. Ben, a priest in his 70s, had spent many years in therapy dealing with the aftermath of his abuse. He described a day when things became too much: *"I had a day when I knew if I lay down and turn my face to the wall, I would not get out of that bed again. So, I was very near cracking" (B, p. 25).*

Here, Ben's "*laying down"* may signify the end of the battle, the 'laying down of arms'. This finality is perhaps also highlighted in his use of the phrase *"turn my face to the wall"*, which conveys turning his back on life and others, and embracing his aloneness. His use of the present tense here may also suggest that these feelings are not quite in the past for him.

The possibility of connection was crucial for Inka, a single mother in her 40s. She, too, reached the point where she was "*hitting rock bottom" (I, p. 3)*, trying to manage the impact of her childhood abuse and daily distress. However, Inka explained that she had taken things further and had a definitive plan for her suicide: *"I got to the point where I was planning my demise. I couldn't take it anymore … I had sort of planned for a particular weekend" (I, p. 2).* A few days before that weekend, a phone call from the counselling service offering her an appointment saved her life. However, at the time, she did not want to be saved and explained that she only agreed to attend the appointment because she saw it as her final chance to reveal her abuse, something she had never done before. Inka said:

> *… in my head, all I remember is, this is your last chance, Inka, this is your very last chance. Just get it out now. Just tell somebody, and then there would be a reason why you left at the weekend, you know. Then they'll know for sure this is why you left, that you did tell somebody. (I, p. 3)*

Inka conveyed a sense of urgency; she was running out of time and needed to ensure that those she left behind would understand her decision. Her use of *"for sure"* suggests that her family may have had an inkling about her childhood abuse experiences, but she wanted to make sure that someone outside the family was aware of what she experienced and why she ended her life. She switched to the third person when encouraging herself to tell, perhaps suggesting that there was a part of Inka that wanted to live and that this part knew that to do this, she needed to speak about her abuse.

Most participants also reported a search for the root cause of their symptoms. When the pivotal point of being unable to continue was reached, participants experienced a drive to understand how this had happened and where the root cause of their symptoms lay. Helen described this as "*the realisation that actually, you know, all of this stemmed from what happened*

to me in my childhood" *(H, p. 9)*. She may have always known this on some level, but had not fully appreciated, recognised, or accepted it until that moment. Her words *"actually"* and *"all of this"* suggest astonishment or disbelief that everything she had struggled to cope with all her life was a result of her abuse. Perhaps both Inka and Helen needed certainty, to *"know for sure"*.

Sub-Theme 2 – 'Finding Someone to Tell'

Sub-theme two is entitled *'Finding Someone to Tell'* and covers the participants' experience of searching and choosing a therapist. For some, that choice was theirs alone, while others had only partial control over this decision. Like several other participants, Grace's ability to choose was limited because what she wanted was not available. She was in her 50s, worked as a psychotherapist, and had previously attended psychotherapy for her childhood abuse in another country, which she described as *"really good therapy*" *(G, p. 15).* Years later, when "*things started to re-emerge, and the flashbacks came back" (G, p. 24)*, she went searching for a new therapist to support her. Grace said:

> *I had tried a bunch of private therapists, and for whatever reason none of them were available, the [specialist counselling service] kept saying, "well you can come to us", so eventually I did. (G, p. 8)*

There is a sense that Grace was shopping around for a therapist. Her use of the word *"bunch"* suggests that she tried several therapists, including the specialist service. She appeared reluctant to go with the specialist counselling service, possibly because her preference was for a private therapist. This may have been driven by a desire to replicate her previous counselling experience, or perhaps because she was a private therapist, which may suggest that she has some opinion about private versus community counselling. There is an interesting juxtaposition between the unavailability of private therapists and the continued accessibility ("*kept saying"*) of

the specialist service, which may highlight Grace's hesitation or resistance to accept what was available, perhaps because she was holding out for her first choice. Her use of the word *"eventually"* suggests that, over time, she was worn down enough to relinquish her desire (for a private therapist), accepting what was available. This appeared to have been based on need rather than choice. Her need for a therapist with trauma experience was not compromised; Grace's need to feel in a safe pair of hands was critical, perhaps because she needed to know that her therapist could help her gain control over her symptoms.

Some other participants reported that their previous counselling had influenced their decision-making when choosing a therapist this time. Alma, a married mother who was experiencing extreme anxiety symptoms, had previously attended counselling for her anxiety. However, this time, she knew she needed a therapist with different experience and skills. She actively searched the internet for a therapist with the skills she was looking for: *"This time, I specifically l looked for someone who was specialised in sexual abuse … and that made a huge difference … she had so much knowledge of it [sexual abuse] and then also you couldn't shock her …" (Al, p. 6).*

Alma's search for a therapist was a decisive action; she looked for a therapist with expertise in working with abuse survivors. Alma was aware that this experience had been lacking in her previous therapy. Alma's therapist's experience "*made a huge difference"* and may have been the key that enabled her to share her abuse experience this time without fear of judgment or disbelief from the therapist [Alma had tried to share her abuse experience with a previous therapist when she was in her teens, but stopped because she was afraid of the reaction and the reporting]. Alma's concerns about *"shocking"* her therapist with her abuse experiences may have been reduced by the therapist having *"so much knowledge"*. Perhaps Alma expected that a

therapist with knowledge and experience had 'heard it all before', meaning they were unshockable, thus facilitating speaking about the unspeakable. While Alma needed an unshockable therapist, as seen above, Grace was searching for and needed a safe pair of hands. Perhaps the qualities needed in a therapist change depending on where the participant is in their journey of telling.

Many of the participants had no choice regarding their therapist. Ivan was in his 60s and had a long history of mental health issues. His mental health care team suggested he take part in group therapy during an inpatient stay in a psychiatric hospital.

> *I was advised to ummm to go for this programme [group therapy]. It was all new, run by the University's psychology department or something, and err, so I said no problem, it was my emmh psychiatrist, and psychologist said it to me. (IV, p. 1-2)*

Although Ivan did not have a choice about who his therapist would be, he still had a choice, albeit a strongly encouraged choice, as to whether he would attend the group therapy or not. His compliance with his team's suggestion may have been influenced by his perception (similar to Alma's) that they were experts who knew what was best for him. The use of *"my"* when referring to his psychiatrist and psychologist suggests a sense of connection and belonging, perhaps based on trust that they knew what was best at a time when Ivan might have been uncertain due to a relapse in his mental health.

Sub-theme 3 – 'Deciding What to Tell'

The final sub-theme in this first GET is *'Deciding What to Tell'*. This concerns the choices and decisions that participants made about how much of their childhood abuse experiences to share before and/or during the early stages of therapy. An understanding of the

mandatory reporting laws and requirements influenced most participants' decisions (See Appendix M for more details).

Mandatory reporting was explicitly discussed as part of the intake process at the start of therapy for most participants (in line with best practice, see Chapter 2), leading them to question what they would reveal about their abuse experiences. Helen, a mandated reporter in her professional role, said her therapist discussed reporting with her at their first session. This prompted some self-reflection and questioning about her abuse and how much she wanted and was willing to disclose. She said:

> *Even just kind of sitting there thinking, okay, what am I going to say? What am I not going to say? How can I say things? How can I not say things? Ummm because it really made me focus on that piece. (H, p. 2)*

The use of self-questioning suggests that Helen felt she had agency over these decisions, despite the reporting requirements, perhaps because she did not perceive the reporting requirements as being her responsibility; instead, they were obstacles that could be manoeuvred around by the degree of her sharing. Her choice appeared to be about how much she would share with her therapist: what to *"say"* or *"not say"*, suggesting that there was a dilemma here for her around her degree of sharing.

Sophia, a healthcare worker in her 40s who attended therapy in a specialist service, was also aware of the mandatory reporting requirements before entering therapy. She explained: *"They went through it with me when I I still kinda thought I was I didn't want it reported, so I was very careful kind of about what I was saying and all that kind of stuff" (S, p. 1).*

Sophia had considered mandatory reporting before going to therapy. She was clear that she did not want her experiences reported and so chose to withhold information about her abuse and abuser to prevent her therapist from reporting. Her use of *"very careful"* perhaps suggests

that therapy was dangerous for her; she had to be alert, wary, and vigilant about what she shared. This wariness may have extended beyond words. Perhaps her use of *"and all that kind of stuff"* suggests that she had to be *"very careful"* about her emotions, body language, and other nonverbal ways of communicating, making counselling even more difficult.

In contrast, the mandatory reporting requirements were not discussed at the intake session for a few participants. Anne had no recollection of ever having been told about reporting or its implications by her therapist. Anne, who was attending therapy for the first time and did not know about mandatory reporting, said:

> *We went on talking like a few months, I feel like like seeing her pretty much, almost weekly, umm I don't remember her ever mentioning mandated reporting at the start. I am not one hundred per cent sure, I don't remember it, and I don't remember being aware of it … if she did mention it, I didn't understand the repercussions of what I might tell her and then what that might mean. (A, p. 3)*

Anne was unsure whether the reporting had been mentioned, but she was clear that if it had been discussed, she had not fully understood its implications or potential impact on her life. Her comments about the frequency of her therapy ("*talking for like a few months"* and *"almost weekly"*) suggest that Anne felt her therapist had ample time to explain the reporting requirements to her but did not, hinting that she may have felt let down or misled by her therapist.

Anne openly and freely explored her abuse experiences with her therapist, unaware of the need for this information to potentially go elsewhere in the form of a mandatory report. An awareness of those implications would have changed things for her:

> *… if I had known those implications, I would never, I would've made somebody up. I would of like and I remember as well feeling angry that I would have had to do that. (A, p. 8)*

Being forewarned by her therapist and fully understanding the reporting requirements would have given Anne the agency to decide what she shared, like it did with Sophia. Her use of *"never"* is decisive, demonstrating that Anne would not have been willing to share her experiences if she had known about the reporting requirements. Instead, she would have taken active steps to protect herself from reporting by *"making somebody up"*, suggesting that Anne was fearful about her abuse being exposed and would have done anything to keep it secret, and angry that reporting laws would have meant that she had to conceal the truth in therapy.

Many other participants considered using their agency in a similar manner. Although only a few withheld or changed information about their abuse or abuser, most considered it. Rebecca, a trainee psychotherapist in her 30s, reported that a friend had suggested giving false information "*cause I really was considering spelling his name wrong on the report or something" (R, p. 37).* However, Rebecca felt that this was not an option, saying: *"I don't think I could have done that. I don't think I would have felt right doing it, so I think for me ultimately it was give the real name or don't do it [therapy]" (R, p. 39)*. Despite her desire to avoid the reporting process and its potential consequences, withholding or changing the truth did not align with Rebecca's values, beliefs, or self-picture. Therefore, this became a binary choice: *"give the real name or don't do it".*

Some others shared this view of being fully committed to the therapy process. Alma was also fully committed to the therapy this time and everything that entailed. During previous therapies, she had said that she did not know her abuser or that he was deceased, thus ensuring that the therapist could not make a report. This time, things had changed:

> *I was like, if I'm doing it, I'm just doing it. That was my thing, you are either doing this, or you aren't, no half-arsing ummh, if you reporting to Tusla, you're going to the Guards and not be coming back in five years' time, a fucking mess again because I didn't go to the Guards. So you know, like I just want to move on, like I*

> *can't go back to that girl who was fucking running home in case her husband was doing something, you know, like. (Al, p. 26)*

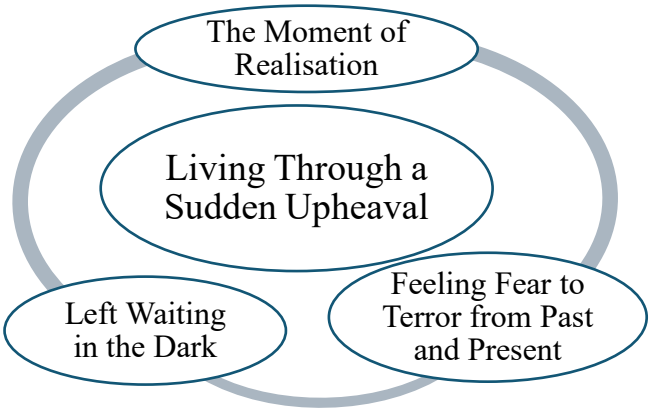
Alma made the conscious decision that she wanted to move on from the struggles related to her abuse and stop the cycle of her mental health improving and then declining, as conveyed by her words, *"not coming back in five years a fucking mess".* There was a sense of things being repeated, which led to a frustration with herself, highlighted in her harsh language when talking about her previous self. Alma needed to do something different for her mental health and well-being to improve. Hence, she committed to the process, whatever might be involved: "*if I'm doing it, I'm just doing it"*.

In summary, GET 1 *"Figuring Out Disclosure"* covers the complex processes and decisions that participants engaged in before or early in therapy as they contemplated disclosing their abuse experiences. The motivations behind their decisions to share such experiences and the selection of individuals to whom they disclosed were explored. The therapist's knowledge and experience were crucial in facilitating this process. The second GET, presented in the next section, considered the participants' experiences as they learnt that their abuse had to be reported.

GET 2 – Living Through a Sudden Upheaval

The second group experiential theme, *'Living Through a Sudden Upheaval'* (illustrated in Figure 3), reflects participants' lived experience of the moment their therapist informed them that a mandated report concerning their abuse was required, as well as how this experience changed over time. There are three sub-themes: *'The Moment of Realisation', 'Feeling Fear to Terror from Past and Present',* and *'Left Waiting in the Dark'.* Each will be considered in turn.

Figure 3
GET 2 – Living Through a Sudden Upheaval



Sub-Theme 1 – 'The Moment of Realisation'

The first sub-theme, *'The Moment of Realisation'*, covers how participants responded once the need for mandatory reporting was brought into the therapy by the therapist. Almost all participants reported a sudden and unexpected somatic response. James, who attended therapy at a specialist counselling centre and had experience of being a mandated reporter in his professional role, described this moment as "*a shock, absolutely it was a shock … well, I think he probably saw my jaw hitting the floor … a visceral reaction I think yeah" (J, p. 6)*. James's repetition of *"I think"* could be an attempt to minimise his emotional experience by limiting his experience to thought, blocking out any emotional feeling. His description of *"my jaw hitting the floor"* conveys the unexpectedness of the shock; perhaps, unlike his emotional response, his physical response could not be controlled or minimised. The combination of being unable to hide his shock and having it witnessed by his therapist (*"I think he probably saw"*) may have exposed James's vulnerability; the suddenness of the shock stripped him of defences that would usually protect him. Nevertheless, his use of *"probably"* suggests that he was holding out hope that the therapist did not notice his reaction. Perhaps in that moment when mandatory reporting came in,

James experienced a double shock: the shock of the report being made and of his vulnerability being exposed.

This was a similarly intense experience for Anne, who had no prior knowledge of reporting before therapy, recalled:

> *It was horrible. I remember it was like, it was such a physical representation of that flight or fight like. I was like out of body experience, was just like I am just going to run out of here I'm going to jump out the window. I need to get out of here … this is having a really big impact. (A, p. 4)*

It appeared that as soon as reporting entered the therapy room, there was a change in how Anne experienced the therapy space. Her use of *"flight or fight"* suggests that she was responding to a perceived threat from which she needed to escape. Perhaps therapy became dangerous for her in that moment. Her instinctive, shock response was fight or flight, and her instinct was for flight. First, she left her body via '*an out-of-body experience'*, which may have been an immediate instinct to get herself to safety while she was still physically in the room. Her use of the phrase *"I was like out of body",* not *'it was like an out-of-body ',* is noteworthy and may suggest that in that moment she experienced her whole identity being swallowed by her out-of-body experience, the shock at reporting swallowed her whole self. Second, she considered leaving the room (*"run out of here"*). Her word *"run"* suggests an urgent need to escape. This urgency increased with her next escape route, *"I'm going to jump out the window"*. This shows the level of danger Anne experienced in that moment; jumping out the window, which was likely to have caused her physical harm, felt preferable to staying in the room with the therapist and the reality of mandatory reporting. Anne's description of her embodied initial response to mandated reporting highlights how, in this moment of fear, Anne uses her body and its actions to escape the danger of reporting.

Interestingly, Anne switched from the past to the present tense in her account. Was Anne re-experiencing her experience during the interview? In that re-experiencing, she acknowledged the enormity of the impact mandatory reporting was having on her, saying: *"this is having a really big impact"* maybe the impact continued to be *"really big"*, even though this happened in the past.

Unlike James and Anne, whose *'The Moment of Realisation'* was expressed outwardly, Sophia kept her feelings of shock to herself, hiding it from her therapist. Her response was to withdraw from the therapist and close down, perhaps withdrawing from the perceived danger. She said, *"I suppose I didn't really w- w- want to talk about it much, because I was quite shocked kinda in the first place … I definitely didn't feel like I wanted to talk about that any more, I suppose I was scared that (sigh) that I would say more … make it worse" (S, p. 5).* Sophia's stuttering and faltering speech may capture her anxiety as she remembered this event, similar to Anne's re-experiencing. Her response led to her disengagement from discussing the reporting process or her abuse further for fear of making the situation worse.

Only a few participants recounted that when they were informed by their therapist of the need to report their abuse, their *'The Moment of Realisation' was not experienced as significant or traumatic as others.* Ivan said

> *"I said, I know, I have no problem with that (reporting), sure … I knew anyway …. I was aware of it (mandated reporting)… from general watching, reading what was in the legislation … yeah so she went ahead anyway, and I said fine, you know ummh no problem" (IV pp. 7&8)*

Ivan's use of *'I knew anyway'* suggests that he had already thought about his abuse being reported based on his knowledge of mandated reporting, and knew that his therapist would have to report

it. Perhaps it was this knowledge and prior thought about his own abuse that protected him from any adverse experiences in the moment of realisation when his therapist brought up reporting.

Sub-Theme 2 – 'Feeling Fear to Terror from Past and Present'

Once participants had processed the initial shock (as discussed in sub-theme one above), most reported fear surrounding the reporting process and its implications for them, their families, and their lives. The second sub-theme, *'Feeling Fear to Terror from Present and Past'*, covers these experiences of fear, which were on a scale of intensity, from fear to absolute terror, which encompassed both current fears and old ones that had resurfaced or been re-experienced. For most participants, this fear encompassed both past and present experiences. Ben had been in therapy on and off for more than 20 years, yet this was the first time a therapist had said that his abuse needed to be reported. His abusers had been deceased for many years. However, the first change in Irish law included the requirement that all childhood abuse must be reported, even if the abuser was deceased (see Chapter Two for more details). Ben spoke emotionally about how, in the moment when reporting was brought up, old feelings of fear and terror arose in him. This terror was of people finding out about his abuse, and triggered a memory of a terrifying event that happened when he was a child. The prospect of mandatory reporting re-triggered this terror:

> *It was during the session that I would have been aware that I was trembling … with the anger, afterwards I realised it wasn't anger it was fear and that fear is right back into childhood … that fear is the child's fear really ummh but part I would recognised … ummh of the perpetrator at the hall door of our house, and he's drunk, I'd say coming up to Christmas, I think it was in fact and ummh being terrified that he was going to say something that would reveal what he was doing … and it's very like that moment now that was a child's fear, but that's why I say that it was a revelation to realise the trembling had more fear in it than anger. (B, p. 26)*

A process was at work here for Ben: a range of emotions was triggered. This began during a session, but the true extent of the fear and terror took time to emerge. Ben's first awareness was of his physical response, which demonstrated the embodiment of his fear. This included *"anger"*, which was strong enough to cause his *"trembling"*. His use of *"afterwards"* suggests that once the initial anger had subsided, there was space to delve deeper and discover that underneath his anger was fear, and not just fear, but "*the child's fear*". His use of "*the"* in *"the child's fear"* may suggest a separation between himself, the adult, and the *"child"* who was abused. However, there was also some connection between the two parts, as his child part was the "*part I would recognised*".

Ben used the word *"fear"* six times, suggesting that his fear and terror were vivid and powerful and may have come from his inability to control or prevent what was happening. In the present, this inability to control was replicated at that moment in therapy when mandatory reporting was mentioned; he felt helpless, disempowered, and at the mercy of the therapist concerning his abuse being reported. His reference to the perpetrator being *"drunk"* suggests that Ben experienced unpredictability and uncertainty as a terrified child. His fear that "*he [the perpetrator] was going to say something that would reveal what he was doing*" suggests that Ben's fear was around his abuse being revealed: his parents finding out, and Ben as a child feeling the shame of his secret being told by his abuser. Although this experience was in the past, the prospect of mandatory reporting triggered it in the present.

Ben reflected on the similarities between his past experiences and being in the room with his therapist when mandatory reporting was mentioned. He said:

> *I think it is something that should be borne in mind, that when a therapist has to report in a way that is unacceptable to the client, they too are being caught up in, are being made ummmh quasi- abusers in a sense do you know. (B, p. 26)*

In his memory, Ben feared that his abuser was going to uncover his abuse. In the present moment, in the therapy room with his therapist, Ben's abuser was replaced by his therapist, who was going to expose him and share his abuse. Both had the power to 'tell', and both had disempowered Ben, and although the roles are very different, in that moment, for Ben, they were the same.

Some participants used metaphors to describe the fear and terror they felt about mandatory reporting. For Helen, her fear was expressed via the metaphor of a *"runaway train*" *(H, p. 67),* which she feared she would *"have no control over" (H, p. 67)*. For Inka, her abuse was "*roll of thread" (I, p.11)* that she held tightly until the mandatory reporting made her *"lose grip of it and no matter like, you know, with that roll as you're pulling back the thread, it's going everywhere and so I had lost that control" (I, p.11).* Both Helen and Inka eloquently use their metaphors to describe how they feared mandatory reporting would mean they would lose control over their abuse. For Grace, it was "*a wall … a really high wall" (G, p. 21)* which signified the unknown impact reporting would have on her life. As she described this wall and its potential impact, she repeated *"god", "oh my god"* and *"god no" (G, p. 22),* perhaps communicating her disbelief and lack of power in the reporting of her abuse.

Anne's fears about what might happen and how that would affect her life and family were more intense:

> *Terror absolute terror yeah, like I've never, like, I don't remember ever feeling that way before. I was absolutely terrified. I was catastrophising. I was imagining like people showing up to my pho [phone], I was imaging my phone ringing and somebody going, what is going on what's all this about like I was so terrified (A, P.5)*

> *Terrified, yeah terrified really like shaking … in my head, it was like the SWAT team is going to arrive at the door. (A, p. 29)*

In the moment when Anne's therapist said that her abuse needed to be reported, she experienced a flooding of intrusive thoughts and images about the consequences of this, all of which she found terrifying. She used *"terror"* or *"terrified"* six times in this short extract, suggesting a powerful terror-stricken state at the mention of mandatory reporting. Unlike many other participants, Anne did not report any triggering of past fears. Her use of *"ever"* suggests these feelings were new, possibly making them harder to contain and process.

Anne's level of terror could have been compounded by this unknowing, which led to her playing out different situations in which her abuse was exposed, perhaps as an attempt to prepare herself for what might happen. She imagined people phoning and asking her about what she had done and the *"SWAT team"* arriving at the door. Both suggest that Anne felt she had done something wrong, for which she would face consequences. The extreme image of a *"SWAT team"* arriving at her door supports this suggestion of wrongdoing. Later in the interview, Anne alluded to the root of this terror of having done something wrong, which stemmed from her uncertainty about her abuse and the consequences if it were to be reported and become official. She said: *"me dropping this massive bombshell of something that I wasn't sure happened"(A, p. 24)*.

Sub-Theme 3 – 'Left Waiting in the Dark'

The third and final sub-theme in this GET is *'Left Waiting in the Dark'*, which covers participants' experiences as they waited for a response from Tusla or the Gardaí about the outcome of the mandatory reporting. The nature of their abuse and the level of information included in the mandatory report influenced these responses. The outcome varied for each participant, reflecting their unique experience (see Appendix L for more details).

Some of the participants found the waiting period difficult. Sophia described the time between her therapist making the mandatory report and hearing from Tusla:

> *… that was quite stressful, like not really knowing if something was going to happen or not … maybe two weeks … in the back of my mind I kept thinking I I kinda thought that they might not that err that you know that they might not be able to do anything … I kinda knew I suppose you know because I had been very careful. (S, p. 13)*

Sophia's use of *"quite stressful"* emphasises the difficulty she experienced while waiting to hear from Tusla. She actively withheld information about her abuse from her therapist to prevent a mandatory report from being made, so when her therapist made the report, she did not think there was enough information for it to proceed. Therefore, although it was a *"stressful"* time, her use of *"I kinda knew"* suggests that she held onto the hope that she had done enough to prevent anything further happening. She described hearing back from Tusla:

> *I got I got a letter … I was delighted then when I got the letter to say that there wasn't enough information do anything about I … I was lucky because it didn't go anywhere, you know, but you know I mean ummmm it should, I'm sure there are other people that aren't that lucky. (S, p.7)*

Sophia's use of the words *"delighted"* and *"lucky"* when describing her feelings about Tusla's response could demonstrate the joy she felt that the investigation could not proceed, and perhaps indicates how strongly she felt about not wanting an investigation. She had worked hard at obscuring her abuse experience during therapy and perhaps felt vindicated by Tusla's response despite her therapist's insistence to report. She described herself as lucky, commenting that others are not so lucky, maybe suggesting that she realised that although she attempted to keep her abuse experiences out of therapy, she had no control over Tusla's decision. This was out of her control.

Unlike Sophia, whose wait was filled with stress and anxiety, Ivan's wait was different and involved hope for justice. Ivan, who had experienced institutional childhood abuse, was waiting for a response from the Gardaí following his mandated report. He said: *"I started thinking about the perpetrators I guessed they were dead, but ummh I don't know … there was a bit of expectation that the detectives might come up with something" (IV, p. 15).* While he waited, Ivan had time to think about his abusers and where they might be. Although he *"guessed"* they were deceased and so nothing could be done about his abuse, the reporting opened a possibility or *"a bit of expectation"* that he may get some external recognition. This never came for Ivan, as when the Gardaí investigation concluded, he was informed: *"the two of them [perpetrators] were dead, and the police told me that it took them two years to find that out"(IV, p.14).* Ivan was left feeling angry, he said, *"I would have liked it to have been highlighted [exposed]… it was systemic … and nobody done anything about it" (IV, p. 15).*

Rebecca initially did not want to report her abuse because she assumed that it would involve a criminal court case, and she did not feel she would cope with that. However, talking with her therapist helped her change her mind and support the mandatory report. She spoke emotionally about her wait for the outcome of the report, and how the subsequent experience with Tusla was like *"a second trauma in some ways" (R, p. 25).* She explained:

> *… they [Tusla] sent a letter to my therapist. I can't remember what the letter said, but to her, it suggested that they weren't going to look into my report in any way because there wasn't enough information. So I tried to call them … I couldn't get through for days … I just so happened to know one of the social workers that worked there. I asked him and he got the lead social worker to call me. … I guess even that was annoying … I had to pursue it, you know, and they are meant, their jobs are very important, and then they are given information about perpetrators, and they don't do anything about it …… [looks sad and begins to cry] I think, I was thinking of my younger self and thinking she had been failed and let down*

> *and it may be tears of frustration as well (laugh) that I put myself through this and for what … yeah not even a phone call. (R, p. 24)*

Rebecca did not receive the information about her report directly from Tusla. Instead, she gleaned the outcome from a letter sent to her therapist, illustrated by her use of *"but to her"* and *"it suggested"*. Her phrase *"in any way"* may indicate the extent of her disappointment over the outcome, that Tusla were not going to consider any aspect of her report. Rebecca's disappointment may have become annoyance and anger when her attempts at connection and discussion with Tusla proved futile. This is evident in her use of *"even that"* and *"pursue it,"* which hinted at her expectations that Tusla would want to speak with her, because she had experience and information about potential harm, as this was their area of responsibility. These feelings were confirmed as Rebecca continued her account, and she considered the enormity of this. Her language in the quote suggests that two parts of her were affected. Her *"younger self"* was *"failed and let down"*, and her adult self*, "I",* was perhaps disrespected, unrecognised, and disregarded, leading to her feelings about the Tusla response as being like a *"second trauma"*.

In summary, GET 2 *'Living Through a Sudden Upheaval'* covers the emotional turmoil that participants faced upon learning their abuse was to be reported. The immediate impact of this revelation during the session and its lingering effects have been explored. Participants articulated feelings of fear that manifested in the present moment, causing memories of past traumas to resurface and creating a complex emotional landscape. The anxiety of waiting for the outcome of the mandated report added another layer of emotions for participants to negotiate. Focus will now turn to GET 3, which focuses on participants' experiences of how the therapist and the therapeutic relationship impacted their overall experiences with mandated reporting.

GET 3 – A Turning Point, Held by the Therapist

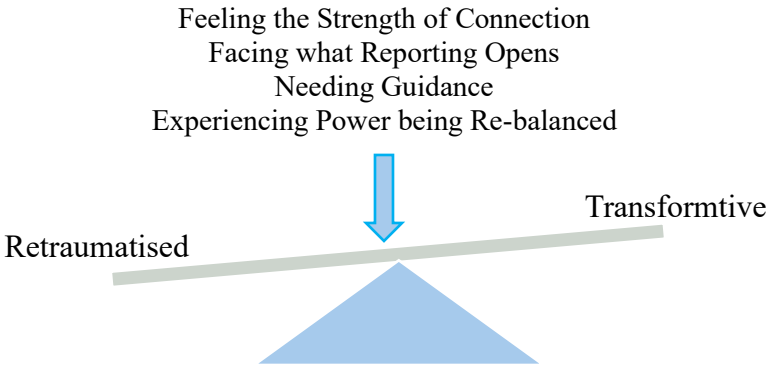
In the third GET, the impact of the process of mandatory reporting, once triggered by the client's intentional or unintentional disclosure about their childhood abuse, was described. The therapist's holding of this, both emotionally and within the process of reporting, including how they communicated about and engaged with the reporting, influenced the participant's overall experience of mandatory reporting. This is an outcome that lies on a continuum, from being re-traumatised at one end to being transformed at the other, with all points in between.

Some participants experienced the process of reporting as re-traumatising, likening it to their abuse. Ben described it as *"being made do something I don't want to do" (B, p. 27)*. At the other end of the spectrum, other participants experienced the process as transformative, gaining healing benefits from it. Alma said, *"it just gave me, … freedom"(Al, p. 41).* Some participants moved between these two dichotomies.

Participants' experiences were influenced by four key aspects of the therapy, connected to the therapist's attitude and skill. These aspects informed the creation of the four sub-themes, as illustrated in Figure 4. They are '*Feeling the Strength of Connection', 'Facing what Reporting Opens', Needing Guidance'* and *'Experiencing Power being Re-balanced'*. Each of these four sub-themes will now be discussed in turn.

Figure 4

GET 3 – A Turning Point, Held by the Therapist



Sub-Theme 1 – Feeling the Strength of Connection

The first sub-theme is about the strength of the therapeutic connection between the participant and the therapist before the need for mandatory reporting arose, and the extent to which this connection, or lack thereof, helped to support the client through the reporting process. For most participants, the therapeutic connection was strong and based on a sense of being cared for, which was present before mandatory reporting entered the relationship. Rebecca said: "*I felt very comfortable with my therapist quite soon … she was just very gentle as well, and comforting … she made me feel quite safe (R, p. 7).* Rebecca was describing her first session with this therapist; her description of being *"very comfortable" "quite soon"* suggests she was surprised at how quickly the comfort came. Perhaps she was expecting it to take longer for the therapeutic relationship to develop. The therapist's qualities of being *"very gentle"* and *"comforting"* contributed to Rebecca's feeling of safety.

Ivan also shared the importance of the therapist's qualities for a strong relationship. He had been seeing his psychologist in an inpatient facility for several months. He said "s*he was a lovely woman", "she'd meet you in the corridor …and have a chat with you", "anything you*

wanted, you'd get" and *"she cared that is the most important thing ... she didn't have to do that, it's not in her job"(IV, pp. 28 & 29).* Like Rebecca, this appraisal was based on his therapist's attributes, attitude and actions. Ivan perhaps perceived her actions as a sign of respect and as a way to let him know he mattered. Her meeting his needs was experienced as an act of caring. This was important for Ivan because there was something personal involved, rather than just a matter of professionalism.

Many others shared this feeling of being connected and cared for by their therapist, which was essential for a strong therapeutic relationship. Alma described two ways her therapist made her feel cared for. First, she said: *"so things like [teaching her self-care techniques] would of put me in a place where I was very comfortable with her ... always kind of different ways of helping me along or of thinking of me" (Al, p. 7).* Like Rebecca and Ivan, Alma's therapist demonstrated care through her actions; in this case, sharing coping techniques. The second way was related to the therapist's handling of mandatory reporting. Alma described how, when reporting was required, her therapist realised she was not coping well and said, "'*We'll just get you in a better frame of mind ... because this is difficult'" (Al, p. 4).* Alma responded by saying:

> *... it felt like she really took me into account, not just what had to be done on the legal side of it, do you know, that it's a human here that maybe needed like a little bit of time ... massive massive ... (Al, p. 3)*

Alma's use of *"really"* suggests that she genuinely felt considered in the reporting process. However, perhaps this went further. Possibly Alma perceived that her therapist had a choice between her client's human needs and her legal obligations. She chose to prioritise Alma's needs whilst still holding the legal responsibility, which was *"massive, massive"* for her.

A few others did not experience such care in the therapeutic relationship. Sophia was attending therapy in a specialist counselling service. She said:

> *… it just didn't feel like we had a good relationship, like I didn't feel like it is going anywhere. I felt there was too much stress kinda on (pause) like what was done wrong to me instead of like, instead of kinda a more holistic approach … she was very much trying to coax out of me err like stuff that happened and then kind of like nearly, nearly made me feel worse about it (laugh) ummm very focused on like the things that happened you know … (S, p. 8).*

Her words, *"going anywhere",* were an interesting choice, perhaps highlighting that she had already decided that the relationship was not tenable in the long term. Her words *"too much stress"* are also interesting and may have a double meaning for her: to *"stress"* could mean to put focus on her abuse, which caused her *"stress,"* an idea which was affirmed later with "*nearly made me feel worse about it".* Unlike for Ivan, there was a misalignment between what Sophia needed from therapy – to consider all aspects of the abuse, including how it was affecting her life and daily functioning – and the therapist's focus, which was on the details of the abuse. This may be why she felt the therapy was *"not going anywhere*". Sophia's use of the words *"very much trying"* and "*very focused"* to describe her therapist's attempts to elicit details about her abuse indicates pressure. This, along with feeling the details were being *"coaxed"* out of her rather than freely given, suggests she may have experienced the therapist as persuasive, controlling, or manipulative.

Grace reported a similar experience. She explained:

> *… it felt to me like he was pushing an issue with me, it felt like (laugh)… he didn't believe me about my abuse, and he was err pushing it [the report] with me because I would then retract the abuse so there wouldn't be a mandatory report. That's what it felt like, so I went back into him at the next session … and basically he agreed that well (pause) kind of yes that's what (laugh) he was saying (G, p. 3)*

Like Sophia, Grace had a *"felt"* sense about what was happening in the therapeutic relationship. Her experience was around her therapist *"pushing"* something with her, conveying

the force, pressure, and momentum she felt being applied to her. Her laughs may have been an attempt to reduce the impact of not being believed. Grace felt her therapist was using the mandatory report to challenge the truth of her abuse. Her word *"retract"* suggests legal connotations. She may have felt like she was on trial or being cross-examined, further evidencing the level of pressure she felt from her therapist's hidden intention.

Due to issues in the centre she attended, Inka briefly attended a second therapist for a few sessions over the phone during Covid, Inka shared;

> *... she was horrible, I didn't get on well with her at all ... she kept telling me that the abuse was sibling rivalry. That was exactly the words she used … on one occasion I actually hung up the phone on her ... I got so upset over the things she was saying to me about sibling rivalry and that maybe I misconstrued what had happened (I, p. 59)*

Inka's experience was like Grace's in that her therapist did not believe her abuse experience. However, unlike Grace's therapist, Inka's was explicit in challenging her about it, renaming it as *"sibling rivalry"*. Inka's use of *"kept"* is similar to Grace feeling pushed and Sophia feeling *"coaxed"*; there was a sense of persistence in all three experiences. This may be because the thing being insisted on by the therapists was being met with resistance from the participants. Inka's phrase "*exactly the words she used"* suggests that she felt she had to prove to the researcher what had been said, perhaps because it was so unbelievable. Inka's *"so upset"* links to Sophia's *"too much"*, highlighting the impact of not being believed or listened to by the people the participants turned to for help, which in turn led to these challenging therapeutic relationships. All three participants stopped seeing these therapists after these experiences. Inka and Grace made complaints about their therapeutic experiences, both of which were upheld. Sophia's therapy dwindled out during COVID-19, when telephone counselling was introduced.

Sub-Theme 2 – Facing what Reporting Opens

The second sub-theme in this GET is entitled *'Facing what Reporting Opens'*. At the turning point, participants described having to face whatever the reporting process opened up next for them. For some, reporting was experienced as a profound rupture, triggered by participants experiencing the therapist's reporting of their childhood abuse as a betrayal. For some, this situation represented a profound sense of personal betrayal, which was compared to their prior experiences of abuse. Conversely, for others, feelings of betrayal were either minimal or absent altogether, thereby enabling the emergence of alternative experiences related to the process of mandated reporting. Reporting opened a new, unexpected pathway to action.

Half of the study's participants experienced the reporting as a betrayal by their therapist, even if they understood their therapist's legal responsibilities under child protection laws. This betrayal felt both personal and relational. Inka described this experience; she said:

> *... it felt like a betrayal ... I know she had to do it, but at the time, it was like I thought I could trust you. I thought you were there for me. I thought you were on my side because you'd used all the right words. You had sided with me for everything ... I just felt umm like a betrayal like another abuse ... (I, p. 34)*

Inka's use of *"I thought"* three times suggests the depth of the betrayal, which led her to question the legitimacy of the important aspects of the therapeutic relationship: *"trust"*, being *"there for me",* and *"on my side".* The betrayal led her to question her therapist's actions, evidenced by phrases such as *"you used all the right words"* and *"you sided with me".* This betrayal was marked by deception, and for Inka, it was experienced as *"another abuse".*

She goes on to share the impact of this betrayal on her, she emotionally shared;

> *... when you are in the depths of of depression and on the edge of suicide, and this person puts their arms around you, and you start to see a tiny little glimmer of of of hope or of survival, and then for them to rip the carpet out from underneath your feet ... especially if you don't have any kind of trust ... (I, p. 64)*

Inka initially experienced her therapist as protective and nurturing at a time when she was alone and despairing. There is something intimate, gentle, and caring in Inka's description of her therapist putting *"their arms around you"* when she was at her most vulnerable, suggesting that these feelings were embodied for Inka. Her use of the second person suggests a separation between herself and the experience, which may have been too painful to remember. Her use of the word "*rip"* instead of the more widely used *"pull"* also indicates the extent of the pain and hurt caused by the betrayal.

Inka later spoke about the impact on her therapy and how she overcame the betrayal. *"I wasn't going to go back, I was bubbling absolutely bubbling with every emotion under the sun, feeling anxious, frustrated, angry"(I, p. 65).* When asked why she continued attending therapy after the reporting, Inka said; *"I think it was subconscious, she is my only safety net … I knew for my own wellbeing and for the wellbeing of the children … a little bit at a time until I realised that I could trust her again* **"** *(I, p. 67).* The safety offered by her therapist, the benefits of therapy for her and her children and time helped Inka rebuild the trust with her therapist.

Ben's sense of betrayal did not come from his therapist but from the reporting laws. His report was made when the law changed (as noted earlier) so that all retrospective abuse had to be reported, even if the abuser was deceased. Ben found it difficult that his name would be reported and recorded. He said:

> *… it's like getting screwed all over again. Like I say it's being bought where I don't want to go (raised voice), and that all has to do with the name. It it's that, who has my name, as me. That's me … but it is the idea that some dark stranger sitting at a desk [is going to know] …no choice whatsoever. (B, pp. 15+16)*

Ben's experience is like Inka's, who described the betrayal as *"another abuse" (I, p.10)*. For Ben, this was *"getting screwed all over again".* He also drew comparisons between

mandated reporting and being abused. His use of *"being bought where you don't want to go"* suggests that Ben did not feel he had any control over his name being given in the report, just as he did not have any control over his abuse. His words *"dark stranger"* suggest danger in his abuse and the reporting. There is a sense here that for Ben, the 'bad guys' (his abuser) and the supposedly 'good guys' (Tusla) are one and the same, and they both want him to do something he doesn't want to do, making the reporting process the worst kind of betrayal.

The other participants did not feel betrayed by their therapists' reporting their abuse. This lack of betrayal opened up different experiences and allowed them to have different relationships with mandatory reporting. Helen said:

> *... it [mandatory reporting] allowed me that, that sense of removal, that this was mandatory reporting, it wasn't me reporting ummm and that was, that was important to me. I think that piece around going no they made an action, and there is a consequence to that action and that, that's not, I'm not, if you like, I'm not driving that consequence, that was, that was really important to me ummm yeah that yes that was that that she made the reporting, it was mandatory reporting it wasn't me reporting ... (H, p. 28)*

Importantly, Helen perceived that reporting was the consequence of her abuser's actions, rather than her decision (*"I'm not driving that consequence"*). She twice said, *"It wasn't me reporting,"* suggesting she was afraid to make the report herself. The mandatory status of the report provided her with protection and perhaps even freedom: *"I am not doing the reporting, I'm merely helping myself to flourish. I can talk about it now" (H, p. 26)*.

Mandatory reporting also helped James, but in a different way. He explained:

> *... putting your name to it [the mandatory report], you know and saying yeah, you know, j'accuse ... ummh something that had to be done, it's as simple as that ... I'm calling him out and saying look, I am accusing you, you did this, you know and I feel that you're that you're still a risk and that you could still and that you could still ummh behave in that way you did. (J, p. 20)*

Unlike Ben, who did not want his name used, and Helen, who perhaps needed the mandated aspect of reporting to name her abusers, James was pleased to have his name on the report and the chance for his abuser to know it was he who was holding him accountable. Perhaps the possibility of younger family members being at risk, along with the mechanism of mandated reporting, gave James the confidence and clarity to take action ("*something that had to be done, it's as simple as that"*) to confront his abuser, something he could not do in his 20s.

The reporting also helped Alma right past wrongs. She spoke passionately:

> *... somebody has to say stop it, like my mother and I still don't understand, and my aunt has watched their nieces and nephews be brought up by him, knowing it, I do not know how you do that, I don't ... but I won't be doing that, you know. (A, p. 42)*

Alma's immediate and extended family had been through extensive, multi-generational abuse, with the women in her family being sexually abused by family members for decades and being unable (or perhaps unwilling) to speak up or protect those most vulnerable in the family, the children. Alma had told her mother about being sexually abused by a family member when it was happening, but her mother took no action to stop it. Alma also believed her aunt knew her (aunt's) children were being abused by the same abuser, but took no action. Through therapy, Alma came to realise that: "*none of them were going to report him ... I knew there was no one to go to (laugh) you're doing this or no one is doing this ... one hundred per cent nobody was going to save me" (A, p. 9).* This realisation that nobody in her family was ever going to stop or report her abuser or *"save"* her meant that the responsibility was hers. Alma went on to describe how the mandatory reporting process helped her:

> *... they have to live with that, I don't because I had the option, yeah I done it all like, and that's where it has been a blessing for me to be able to report ... it just gave me ... freedom. (A, p. 41)*

The reporting process gave Alma the option to name her abuser and put an end to the generational abuse in her family. Her word *"freedom"* is compelling and suggests that the process of reporting may have freed her from the silence carried by her female relatives, and perhaps offered freedom from abuse to the female relatives coming after her.

Sub-theme 3 – Needing Guidance

Sub-theme three is about how mandatory reporting led participants to an unexpected and unfamiliar place. Participants turned to their therapists for guidance, support, and information so they could gain control and agency in this unknown landscape. The therapists' ability and willingness to meet these needs impacted participants' experience of reporting.

Some participants, such as Anne, felt that their needs in this regard were not met. She said:

> *… she didn't control the situation, and she she gave out mis-, like she said things that weren't true, like she stoked this fear and like that, what she said about oh they might show up to his house, they might contact like that … she lead me to believe that by me just saying that first name and possibly the relation to me that that was going to be enough … she told me something that wasn't true … she communicated very poorly what what umm the process of reporting was. (A, pp. 34-35)*

Anne's word *"control"* suggests she expected her therapist to take the lead and manage the *"situation"*. Instead, Anne perceived that her therapist said, "*things that weren't true,"* which *"stoked the fear",* instead of reducing it, as Anne expected. By sharing incorrect information, this therapist appeared to cause harm to Anne rather than reduce or prevent it.

The therapist's lack of accurate knowledge and information about the reporting process also led Anne to question her competence and training, she said; "*it seemed like she didn't know what the process was … so maybe it was a failing of her training" (A, p. 37)*. Similarly, when Sophia described her therapist's handling of the reporting process, she said, "*I had a feeling*

maybe she was a little bit incompetent … I don't think she was the best therapist" (S, p. 15). For both, there is perhaps an expectation that understanding the reporting process is one of the key competencies of being a therapist, with the dual role of a legally mandated person.

At the time of her interview, Grace was a psychotherapist who had knowledge of and experience in reporting. However, during her mandated reporting experience, she had not yet completed her psychotherapy training and had no knowledge or understanding of the process. She spoke about looking for information and guidance from her therapist:

> *… he didn't really explain what would happen, you know, I said what would happen, he said well, it would go to the duty social worker … and they will get in touch with you at some stage but like that was it … I don't even know what happens … you know I had no idea, are the Guards involved? I knew nothing. (G, p. 5)*

Her words *"didn't really explain"* and *"that was it"* suggest that her therapist offered a level of explanation and guidance, but not enough to answer her questions and offer her more certainty and control. This lack of attention to her needs is also suggested by her having to ask her therapist about what would happen rather than them offering her the information. There appears to be a mismatch between the information conveyed by the therapist and what Grace needed. Although she was told that a social worker would make contact, she did not know what would happen next. Her language suggests vulnerability, helplessness and maybe defencelessness in this new situation, and her need for detailed guidance was maybe her way of trying to gain some sense of control over this unfamiliar situation she was in.

Ben shared a similar feeling when he said, "*in my therapy, I am not there as the expert, and there is a huge element of powerlessness involved" (B, p. 43)*. This suggests that Ben viewed his therapist as the expert and looked to her for information and guidance, echoing Anne's expectation that her therapist would be knowledgeable about the reporting process.

Conversely, some of the other participants reported receiving the right amount of information and guidance at the right time from their therapists. Rebecca said:

> *... she did go over everything with me, what she knew of it, what the process would be ... I did feel a little bit reassured ... I think I felt more in control, ummh that maybe I had more autonomy than I would have thought, in that I think in at first I thought the Guards would be getting involved and so when she explained that they wouldn't be, I think maybe that was a relief. (R, p. 32)*

It appears that Rebecca's therapist was knowledgeable about what was involved in reporting and could go over *"everything"*, suggesting that all Rebecca's concerns, questions, and uncertainties were addressed. This newfound information and guidance may have led to feelings of being *"reassured"*, *"more in control"*, and having *"more autonomy",* in contrast to Anne's experience above.

Similarly, Helen's therapist's sharing of information and direction helped her to make crucial decisions about the reporting. She said:

> *... in my case there were [multiple] perpetrators, and I didn't intend to disclose all of them, but I suppose having disclosed the first three and the forms were completed for those ... and also the fact that, you know, my therapist has said to me with with the first three "ok this is the procedure, this is what will happen. You will be phoned, you will be asked if you want to take it further, if you don't want to take it further there will be no follow up. If you want to take it further then you will get another phone call" ... I was like ok now I'm now comfortable [to report the other perpetrators]. (H, p. 26)*

Once Helen had become acquainted with the process by completing the mandatory reporting forms for three of her abusers, alongside the fact that her therapist had explained the Tusla procedures, she had the confidence and fortitude to report her remaining abusers. Her phrase *"also the fact"* indicates that her therapist's explanation of the reporting process played a role in her decision to disclose the additional instances of abuse. Helen's use of the term *"take it further"* suggests that she understood from her therapist that she had a choice about whether to cooperate with Tusla in any potential investigation, following the reporting. This guidance may

have helped empower her by emphasising that the choice to engage in this process resided with her, thereby allowing her the necessary time to make a decision before receiving the phone call from Tusla.

Sub-theme 4 – Experiencing Power being Re-Balanced

The final sub-theme in this GET is *'Experiencing Power being Re-Balanced'*. Notably, mandatory reporting places the legal responsibility on the therapist to report any knowledge, suspicion, or disclosure of childhood abuse; this sub-theme is not intended to suggest that this responsibility can be shared with the participant. Instead, it examines how included the participants felt in the reporting process and how this impacted their experience of mandatory reporting as either re-traumatising or transformative. It explores what the therapists did or did not do to facilitate this, including what measures, if any, they took to include participants in the process.

Most participants described feeling that they had been given enough time and space to adjust to the idea of reporting by their therapist. This differed for each individual and depended on the nature of the abuse disclosure and potential risk to others. Rebecca said:

> *... she didn't make me feel like it was something we had to do instantly, that I could have a bit of time to think about it. I guess that helped me I feel like it was that I could return to the second session ... maybe in the second session I was a bit calmer, I had some time to think about it and was maybe more receptive ummh, to hearing about it. (R, p. 10)*

When, in her first session, Rebecca's therapist told her about the need to report, she was adamant that she did not want this and considered not returning to therapy. Her phrase *"didn't make me feel"* suggests that her therapist did not explicitly say that they had time and did not need to report *"instantly"*. Instead, perhaps this was conveyed in how she engaged with reporting and

explained it to Rebecca, which gave Rebecca the feeling that she had *"a bit of time to think about it"*. This may have given Rebecca some sense of power and control over the process, allowing her to return for a second session and continue hearing about what reporting would entail. She said, "*we did the report in the third session. I suppose that in itself was a process because I went from ummh, you know not wanting [laughing] to do it under any circumstances to deciding to do it" (R, p. 11).* Rebecca explained that this change was because, "*after the second session I got quite angry, the anger really started to come up in me" (R, p. 12).* However, it was not just the anger that changed things for Rebecca, she said, "*my therapist, at the time I I I think she was quite supportive of that you know I felt like I could be angry" (R, p. 12).* Her therapist appeared to facilitate this process with her by giving her time and space for her feelings about her abuse and reporting to emerge, while keeping the reporting requirements in mind. Her emotional process was not overshadowed or eclipsed by the reporting.

Similarly, Ben said:

> *... she just mentioned it, and she bought it up and sa- said that we would return to it ... she mentioned it, but then we went on to what I was dealing with or what had come up for me. (B, p. 43)*

Like Rebecca, Ben appeared to experience his therapist as holding the legal reporting responsibility and bringing it into the therapeutic relationship, but giving him space and time to decide what happened next. In this way, perhaps some of the power was shared.

Helen said that from her first session, *"I always got the sense of you know th that wasn't going to be a rushed piece that they we were going to take that time with that piece" (H, p. 12).* However, at each session, there was *"a gentle reminder that there would be form filling" (H, p. 14).* Helen went on to describe how the reporting happened:

> *… the forms weren't there, and I think it was about my third session and I I said something, I was kind of like, about the forms, and she said, do you want to do the forms today? And I was like, no I don't, but I was, it was almost as if I was*

> *looking round for the forms and thinking I would have to do the forms. So then the next session, she actually had the forms just on the table, and she said the forms are there, we don't have to do the forms today, we don't have to do them for a while, we will do them when you are ready, but they are there it was always metaphorically present, but then they actually became physically present. (H, p. 19)*

Helen's account, like the others, highlights that her therapist took the lead on reporting, but gave Helen some autonomy over when the reporting would commence. Helen said, *"The forms weren't there",* when she looked around the therapy room for them. Perhaps all the *"gentle reminders"* made her feel as if they were in the room, so she went looking for them. Her inquiry was met with a question about whether she wanted to start the report today, to which she felt empowered enough to say, "*no I don't"*, although she knew that at some point, *"I would have to do the forms".* This feeling of empowerment may also have been helped by:

> *… my therapist kept saying, this is your space for you … this is your space Helen, for you to say what you need to say and I think that was really key for me, to be able to unstopper my mouth and to speak my truth. (H, p. 13)*

Helen felt that her therapy was her space and that she had some control and agency regarding what happened and when, in terms of the reporting. Her use of *"unstopper my mouth"* is very striking and suggests that she could be 'unstoppered' given the right conditions. It also captures the embodied nature of the impact of childhood abuse and how silencing can be an ongoing feeling. Those conditions were perhaps being given some autonomy, choice and power about when the reporting happens – re-balancing some of the power around reporting, which facilitated Helen to *"speak her truth"* for the first time in her life. This also may have contributed to the reporting being made with Helen's cooperation, as it was for Rebecca.

Some others had a different experience with the power imbalance created by the mandatory reporting. Sophia stated that the reporting of her abuse happened in session 10 of her therapy:

> *... well it was just like in relation to things that I had said, I guess over, you know, during sessions in general, and then one day she just said, 'Oh, I'll need to report this ... I have to do this and that's it and it's not my choice either, this is my role' you know ... she just kinda 'right I've got these things [forms] here for you' and this is what is happening ... it was all written and she got me to read it. (S, pp. 6 & 12)*

The need to report was a surprise for Sophia. It came out of the blue; *"one day"* suggests she was given no notice and had no idea the reporting was going to be required. Sophia's recall of her therapist's language (*"I"* and *"my"*) may indicate a separation between Sophia and her therapist, perhaps caused by the legal responsibility of mandatory reporting and how her therapist experienced the weight of this. Sophia wished for something different:

> *... ask me for my opinion more I guess, you know ummmm included me into the process instead of saying like right you know "I have to do this" ... but kinda you know more ask me directly I mean she did kinda show me what she was reporting and she let me read it. (S, p. 7)*

Sophia wanted to be more included in the process than she had been, and for her opinions to be considered. Perhaps she also wanted the reporting process to be more transparent between them, as suggested by her phrase *"ask me directly"*. Her words, *"she let me,"* indicate that Sophia did not feel she had any rights, control, or choice when it came to the mandated reporting, her therapist was in charge and decided what Sophia could and could not do. Towards the end of the interview, Sophia reflected on how things could have been different:

> *... maybe we could have gone through what would that mean and what would that look like if it does get reported, you know ... then who knows I might have actually come to the conclusion that it wouldn't have been a bad thing. (S, p. 22)*

Here, Sophia suggests that if she had been given or felt more agency and inclusion in the reporting process, she might have changed her view and maybe seen reporting as a good thing, perhaps meaning that she would have supported the process and shared more of her abuse experience so that Tusla could have been in a position to investigate, similar to Rebecca.

For many of the participants, the re-balancing of power was around the form filling and how the actual reporting process was completed together, James recalled; "*I was in the room with him when he was filling the form …he was at the far end of the room filling all the things on the laptop … he was asking me questions as he was doing it …I actually preferred that we did it together" (J, p. 10).* The collaborative approach of completing the mandatory reporting form, was preferrable to James as it gave him a sense of inclusion in the process *"asking questions"*, which was important to James that the correct information was included. Also being included allowed him to know that the report was completed and sent, rather than wondering if it had been done. This was important to Alma, too, being included in the process and knowing that the report was sent. Alma said;

> "*she [therapist] just rang me and said … its [the report] going today … she said this is the beginning of, you know, like handing it back, you know and it is another stage so do something, you know go down to the beach and you know pick a stone ….. I still have that stone" (Al, p. 6)*

For Alma, her therapist's sharing of the power around the reporting, making the process collaborative, and also bringing it into her recovery journey, as a significant step, appears to have been important to Alma, as signified by her keeping the stone.

In summary, GET 3 *'At a Turning Point, Held by the Therapist',* participants described disclosure shifting from a personal choice into a mandated process shaped by the therapist's actions. This moment felt high-stakes and exposing, with the potential for either re-

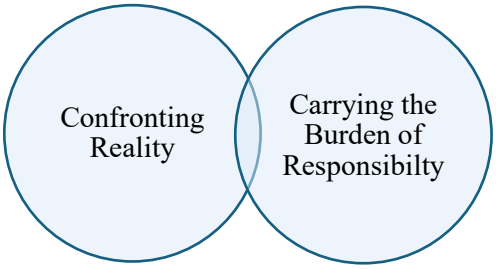
traumatisation or transformation depending on how the therapist held connection, explained the process, and shared power. Some experienced reporting as a painful betrayal that repeated earlier trauma, while others described it as a catalyst for action, enabling them to experience mandatory reporting as a mechanism for opening up new possibilities. The outcome was not inherent in reporting itself but created through the therapist's holding at the turning point.

GET 4 – Finding Agency within the Unbearable

The final GET, *'Finding Agency within the Unbearable*', covers how participants had to face and acknowledge challenging aspects of their abuse from which they had protected themselves for many years, so that the mandatory reporting process could be completed. The first sub-theme, entitled *'Confronting Reality'*, tells of how participants had protected themselves against the possibility that their abuser had harmed others and how, during therapy, the reporting process necessitated confronting this reality. The second sub-theme is entitled '*Carrying the Burden of Responsibility'*. Here, participants' complex feelings about being responsible for protecting others and the reporting laws that require survivors of childhood abuse to report their abuse to protect others are explored. For some participants, this responsibility became a burden which was too heavy to carry and mandatory reporting helped them hand it over. For others, this was not as easy or straightforward.

Figure 5

Finding Agency within the Unbearable



Sub-Theme 1 – 'Confronting Reality'

This sub-theme covers how, during therapy, therapists must help participants confront the reality that their abusers might have, or might still be hurting others, and that this impacts their feelings about mandatory reporting. Many had never considered this possibility before and had to confront this in order to establish whether their abuser was a current risk to other children.

As explored in Chapter Two and noted elsewhere in the thesis, the law regarding the requirements for retrospective or historical abuse underwent two changes during the data collection phase of the study, resulting in three distinct requirements during three separate periods. As a result, not all participants were directly impacted by this sub-theme, as some of the distinct requirements did not involve establishing whether children were currently at risk by an abuser, and therefore, there was no requirement for the therapist to discuss this with the participants during therapy, thus no immediate need for them to confront this reality.

For some, like Inka, who eloquently described that she had never considered the possibility of her abuser harming others before her therapist brought this to her attention:

> *I had never thought of it before. I'd never, it had never dawned on me that there was anybody else, never dawned on me that anything any of that … and then she starts*

> *putting new thoughts into my head, and they start taking over 24-7. That's what was happening with me, umm, and so it wasn't a sudden realisation of yeah. Maybe it was a slow burn over the course of six weeks … okay I can kind of understand why she did it now, you know. I can kind of understand Tusla being involved in it now but (long pause) a slow burner it was a slow burner. (I, p. 53)*

Inka's use of the word "*never"* four times suggests that she needed her therapist's input to consider the possibility of her abuser hurting others; she would not have had this thought alone. Her use of "*putting thoughts into my head"* implies that Inka considered these thoughts to be her therapist's rather than her own, perhaps because they were too painful, and so she protected herself against them. The impact of this possibility on Inka was intense; her use of *"24-7"* and *"started taking over"* implies that this was all she could think about, perhaps indicating that they were too powerful and that she needed to surrender to them. In comparison to this intensity, her words *"slow burn"* (which she emphasised) suggest that it took time and space for her to process and accept this possibility, and also highlights the embodiment of the physical pain she was experiencing from these new thoughts. Inka's phrase "*kind of understand"* may be a tentative acceptance of the need to report her abuse, thus allowing her to find some agency in a difficult situation.

In contrast, for James, the realisation that others may have been (or were being) harmed by his abuser was immediate and shocking. Once the therapist had introduced the idea that others may have, he put the pieces together for himself, saying:

> *… it was a shock, absolutely it was a shock … because at that I, you know, I I hadn't given it too much thought but at the same time when it, when you're in a situation where you're forced to think about it … a visceral reaction I think. Yeah, because umm, you know when you, when you think back to what went on, you would hate to have that inflicted on anyone else you know. (J, p. 6)*

The strength of James's shock may have been partially due to his suppression of this possibility (*"hadn't given it too much thought"*). His use of *"too much"* suggests that he may

have given it some thought but pushed it away. His use of the word *"forced"* suggests that, like Inka, James may not have come to this realisation alone. However, once confronted with the possibility of abuse to his younger family members, "*there was absolutely no question of avoidance" (J, p. 7)*. James found the strength to overcome his avoidant strategies and take action by actively supporting the reporting process.

Some others, like Helen, Alma, and Rebecca, their defences against others being harmed were strong, so it took more than their therapist bringing it to their awareness for them to consider the possibility. They needed something further, a different way to understand and see their abuse. Rebecca said:

> *I remember her using that word, the word crime and that this person is a criminal … so I guess listening to her speak like that, whereas, I, for some reason, never viewed it or that person as a criminal or it being a crime, ummh, it being a risk to others ….. I guess exploring that in therapy and my therapist, I guess giving her opinion that what he did was premeditated, it was planned ummh yeah yeah made me kind of think about it in that way" (R, pp. 14+16)*

Rebecca's therapist's framing of her abusive childhood experiences as a crime, thus making her abuser a criminal, was new for Rebecca. However, she did not have an instant realisation like James's or a *"slow burn"* like Inka's. For Rebecca, it may have been the time and space in therapy where she explored this and heard her therapist's opinion of the abuse being *"premeditated"* and *"a crime"* that helped. She said that "*listening to her [therapist] speak like that"* opened up the possibility. Like James and Inka, when she allowed in the possibility of harm to others, she found agency in supporting the reporting of her abuse to Tusla. Later, she wondered why she had not considered the risk to others herself before, but realised and acknowledged that this process was *"a bit scary" (R, p. 14)*.

Like many others, Helen's defences were built around all her abuse experience, not just the potential for others to be harmed. She stated:

> *… you kind of lived with this forever and and known it inside out, you know. It's my memory, my history, but it really gives a different kind of perspective on it … you're so defensive all the time in your own, you're batting it all the time in order to, you know, live a normal life and and actually and to sit with that and go I need to nurture or nourish or look after myself because these crimes were committed against me … and that's huge (H, p. 23)*

Helen knew these experiences intimately but needed to be defended against them to function and live her everyday life. There is an acknowledgement that this defence and ongoing battle influenced her perspectives. Her use of *"so"* in *"so defensive"* suggests that this defensiveness needed to be extreme to keep out the horror of her abuse and let her live. It is only after her defences were dismantled and time was taken to *"sit with"* and reflect on her abuse that her shift from battling to nurturing and taking care was revealed. The catalyst for this shift was the realisation that her abuse was a crime committed against her, just like it was for Rebecca.

Sub-Theme 2 – Carrying the Burden of Responsibility

The second sub-theme in GET four is *'Carrying the Burden of Responsibility'.* All participants, in different ways, felt the burden of responsibility for others, actual or potential, victims of their abusers. The process of reporting was, to differing degrees, seen as a mechanism for handing over this responsibility. This theme is linked to the sub-theme above, *'Confronting Reality',* for some participants, the realisation that others might be at risk from their abuser (past or present) brought with it a sense of responsibility. For others, the feeling of responsibility had always been present but too painful to acknowledge.

Most participants felt a sense of responsibility towards others. After Anne's mandatory report was made (this was during the first change in the law, where reporting was required even if the abuser was deceased or his identity was undisclosed), she received a letter from Tusla

stating that there was insufficient information to investigate further. Speaking about this letter, Anne said:

> *I still if I read it now, I'd just be like ahhh I felt guilty about that portion of it 'We would encourage this person to give the name to protect current children', which I get completely, 100% completely get it, but it was still like oh it felt like such a responsibility that I hadn't asked for … it was brought on me to like, to keep the secret or protect the children and you know do all these things and I haven't done anything wrong. (A, p. 19)*

Tusla encouraged Anne to disclose the name of her abuser. This made her feel *"guilty"*, perhaps due to an assumption that, by withholding the name of her abuser, she was putting children at risk of harm, a responsibility she *"didn't ask for"*. Anne alluded to a tension between *"completely getting"* that children should be protected from harm, but not being ready to disclose the full details of her abuse. This was a situation in which, no matter which option she chose, someone would lose out. If she protected children, and this protection is of unknown, unnamed, potential children, not tangible children she knows, she suffered and was at risk of harm from her abuser "*I felt in danger, I felt like unsafe if certain people[abuser and his family] found out about this [the report] (A, p. 9)*; if she protected herself, children may suffer. This choice *"didn't feel comfortable" (A, p. 10).* She later succinctly articulated the dilemma when she said, "*children should be protected, but what about the person that was abused as a child?" (A, p. 40*). This dilemma was reaffirmed by Grace, who said *"we have to stop making the victims of abuse responsible for preventing further abuse. It's not our job, we were abused" (G, p. 14).* Both Anne and Grace clearly and directly articulated the dilemma experienced by many participants: how to protect children at risk of harm and themselves as adult survivors of abuse.

James reported becoming aware of the possibility that other children may be at risk of harm from his abuser and how, as a survivor of abuse himself, this made him feel:

> *I just assumed that those kids would be ok, you know to hear that they might not be err was a bit upsetting and maybe made me feel a bit guilty that maybe I should said something sooner [looks upset] … it is very difficult … why didn't I make that connection, I really should have given it a bit more thought beforehand … it makes me feel a bit dumb at times you know that I didn't think about it before. (J, pp. 5-6)*

James's use of the word *"assumed"* may have been his way of protecting himself from the reality that his abuser could be harming other children and from the responsibility and guilt that came with that realisation. Like Anne and Grace, he felt *"guilt"*. However, he was also *"upset,"* which was visible during the interview, perhaps because these children were younger family members (although he did not know them) rather than strangers. His self-critical language suggests that James blamed himself for not stopping his abuser and protecting others. And perhaps illustrates Grace's point about how mandatory reporting of historical abuse places the burden of responsibility for preventing abuse on the survivors of abuse.

Grace also felt responsible for protecting other children from being harmed by her abuser. She, however, went further, passing this responsibility onto the people who could protect the at-risk child. She said, *"I went to speak to the mother of that child and I explained the situation to her and err to make it her responsibility to decide how to protect her child" (G, p. 6).* Grace explained why she felt such responsibility and what it was like to walk away from it when she *"left it to the process" (G, p. 13)* of mandatory reporting:

> *… many people who are abused as children feel responsible for everything … you feel responsible for having been abused, you feel responsible for not caring for other people, you feel responsible for not protecting, you know, so it was really revolutionary to walk away from feeling responsible for everything, I'm like actually I wasn't responsible for anything. (G, p. 16)*

There is a contrast in Grace's description between the heaviness and enormity of the responsibility she had been carrying and the lightness and freedom *"to walk away"*. Her use of

"revolutionary" conveys the fundamental or transformative nature of this process for her. In contrast, perhaps James was taking responsibility for things that were not his.

Helen stated that mandatory reporting helped her with this feeling of responsibility:

> *I suppose one of the nice things about the mandatory reporting is … that I don't have to ascertain is this person a danger to other children, and I don't have to frantically be running round, sort of trying to make everything ok, it's mandatory reporting, I just need to talk to my therapist about me [deep breath], and look after me, and they will do that piece. (H, p. 10)*

Helen appeared to express relief at having gone through mandatory reporting because she no longer had to *"ascertain is this person a danger to other children"* and *"make everything ok"*. All she needed to do was "*talk to my therapist",* after which her therapist and the reporting process would take the responsibility from her.

However, not all participants felt that mandatory reporting took this responsibility from them. This was especially true for Rebecca, she shared:

> *… after doing the report, I know I said I was empowered, but I guess a part of me was relieved as well ummh yeah, because I maybe it felt like I was shifting that sense of responsibility in giving it to the people who were qualified to look into it and do something about it, and I thought oh they're really great organisation finally we have something like this finally I can let go of this a bit. (R, p. 34)*

Like Helen, Rebecca felt *"empowered"* to make the mandatory report and that she could pass her responsibility onto Tusla, who, unlike her, *"were qualified"*. Although Rebecca felt responsible for protecting others, she lacked the means and authority to do so. Perhaps making the report put the responsibility on the organisation that had the power to *"look into it and do something about it"*. However, Tusla decided that there was not enough information to investigate Rebecca's report. She described how it felt to receive this information:

> *… it [responsibility] was given back to me, like here you go take it back, it was as if they said here you go, you take it back we can't do anything … invalidated … it took so long for me to validate it myself, and to see it as a crime and or you know*

> *this organisation is supposed to support people like that but actually what they have really done there is protect the perpetrator. (R, pp. 24-25)*

Rebecca felt that Tusla's response was handing her back the responsibility to protect children that she had given them via her mandatory report. However, perhaps it was more than this for Rebecca. Her word *"invalidated"* suggests that she felt as if her abuse experience was invalidated or rejected by Tusla after she had worked so hard to *"validate"* it for herself. Rebecca felt like they had chosen a side. Instead of supporting her as they were *"supposed to"*, Tusla instead protected her abuser. Rebecca stated that she must balance two elements. On the one hand, making the report to protect others, and on the other, Tusla saying there was nothing to be done. She said:

> *I don't think I have reconciled that, I'm not sure that I ever can. That's the bit that stands out for me, and it's probably the one element [in a whisper] sorry [crying] ... it's the one part of this that I, I can never accept that other people could be hurt. That it's the one part that I have to suppress. I don't let myself think about the perpetrator hurting others because it's too much. (R, p. 31)*

In contrast to Helen, Grace, and James, the reporting process did not take responsibility for protecting others from Rebecca, but instead gave it back. Rebecca described holding this as *"too much"* and something that she needed to *"suppress"* to protect herself.

In summary, GET 4 *'Finding Agency within the Unbearable'* described how participants found moments of agency while facing aspects of their abuse they had protected themselves from for many years. Mandatory reporting required them, with the help of their therapist, to confront the possibility that their abuser had harmed others, bringing an unbearable reality into view. This was a process that, for some, happened immediately with little effort from the therapist, whilst for others, the therapist needed creative ways to break down the defences and allow time for the participants to accept the reality. For some, agency emerged through facing the truth, naming

what happened, and accepting the limits of their responsibility. For others, agency was found in handing over the burden of protecting others to the reporting process when it became too heavy to carry alone. In this moment, agency took different forms, reflecting both the struggle to hold responsibility and the relief of not carrying it entirely.

Conclusion

The study findings have been presented in this chapter. Four GETs, along with their sub-themes, were presented. The first GET, *'Figuring out Disclosure'*, covered participants' experiences as they exercised choice and autonomy regarding the sharing of their abuse experiences. Participants described the circumstances which drove them to seek psychotherapy, often after years of trying to manage alone. For some, searching for the 'right' therapist was a process of research and exploration. For others, that choice was limited. Participants' decisions about how much of their abuse experiences to disclose were informed by their understanding of mandatory reporting requirements and their own needs.

In GET 2, *'Living Through a Sudden Upheaval*', participants recalled the moment in therapy when they were told about their abuse being reported. Some reported an immediate embodied response, while this took longer to emerge for others. Participants recounted how, as the initial response dissipated, it was replaced by terror and fear. This was limited to current fear for some, whilst others re-experienced past fears and terror. Participants also described a period of waiting for the outcome of the mandatory report. For some, that wait continues. For others, the outcome brought varied responses that needed to be processed.

In the third GET 3, titled *'A Turning Point, Held by the Therapist'*, participants shared their experiences with the mandatory reporting process, noting that it was perceived on a continuum of re-traumatising or transformative, contingent upon the therapist's approach. The

quality of the therapeutic relationship emerged as a significant protective factor for some individuals during this process. Conversely, for those who experienced a lack of connection with their therapist, the process was reported as traumatic. The reporting procedure elicited varied responses; for some participants, it was experienced as a profound personal betrayal, leading to a rupture in the therapeutic alliance. In contrast, others found that it facilitated new healing opportunities. All participants expressed a need for guidance from their therapists as they navigated this unfamiliar terrain, a need that was addressed to varying extents. Finally, participants spoke about how they experienced their therapists managing the additional power dynamics inherent in their mandated position and the implications this had for the therapeutic relationship.

The final GET, *'Finding Agency within the Unbearable'*, participants shared their experiences of having to face some painful truths about their abuse. They also reported that their therapists had gently dismantled defences that had been developed to protect them from these possibilities. Importantly, participants had to face the burden of responsibility that mandatory reporting of retrospective abuse places on survivors. This helped some participants accept the reporting process, while it created more tension and distress for others.

Considered together, the four GETs offer a rounded depiction of the lived experiences of the 10 participants as they negotiated the mandatory reporting of their childhood abuse during psychotherapy.

Researcher's Reflective Comments:

I was naive about this stage of the research. I thought that because I had done so much work on the analysis, the findings would be an easy final step; just writing up what I had found. Well, again, the devil was in the details. Yes, I had done all the work, and it was all there, but the challenge now was to choose how to support the findings, which lived experiences to select, and where the convergences and divergences between participant experiences lay within each sub-theme. The feedback I received from my supervisors on the first draft of the findings chapter was that I was interpreting the person rather than their experience; that I was "being too psychological in my interpretations". This was hard to hear because I had worked hard on the first draft and thought it was a good start. It took me some time to find a way to shift my focus while doing the interpretations. I had to let go of my psychology-informed way of interpreting and find my IPA researcher's way of doing this. I realised that it wasn't my interpretation that needed to change, just what I was interpreting; I had to move from the person to the experience. Once I started, I found that I had a groove, and the process became enjoyable. I liked the idea of building a picture of the sub-themes, showing what the meanings were for participants, how and why experiences were similar, and where and how they differed. Below each heading, actual lived experiences were told. My love of detail really helped me with the interpretations. I enjoyed pondering the meaning of the words that the participants had chosen to describe their experiences, as well as the rhythm and flow of their speech. The hermeneutic circle came alive for me in the write-up, as I saw the dynamic connection between the parts and the whole at many different levels. This involved moving close to examine the part and then zooming out to view the whole while still holding the part. I now understand and have lived experience of the 'iterative' nature of the IPA approach. The constant moving back and forth between all the different analytical steps was fascinating to experience in person, having previously only read about it.

Moreover, I can appreciate the complexity of an interpretative phenomenological analysis now that I have finished and am no longer 'in it'. The stepping out gave me distance, which brought clarity and understanding.

Chapter Five

Discussion

"The task is not so much to see what no one has yet seen,

but to think what nobody has yet thought about what everybody sees."

Arthur Schopenhauer

Introduction – A High-Stakes Journey of Disclosure

This study aimed to examine the lived experiences of adult survivors of childhood abuse as they navigated the process of mandatory reporting within the therapeutic context. Using a qualitative methodology, in-depth semi-structured interviews were conducted with 10 participants. Their experiences were analysed through the lens of Interpretative Phenomenological Analysis (IPA), and four group experiential themes emerged. These were *'Figuring Out Disclosure', 'Living Through a Sudden Upheaval', 'A Turning Point, Held by the Therapist',* and *'Finding Agency in the Unbearable'.* Collectively, these themes amplify the voices of psychotherapy clients, presenting their personal, authentic lived experiences of mandated reporting in therapy. In this chapter, these key findings will be discussed and situated within the existing empirical literature, clinical practice and current theoretical knowledge.

The discussion integrates the four group experiential themes, positing that together they represent a high-stakes journey of disclosure. Where disclosure is understood not as a single act of telling (which spans from telling all to actively withholding), but as an unfolding process that begins when participants start to consider sharing their experiences and continues through the reporting process and Tusla's response. Although mandatory reporting was triggered after disclosure occurred, participants experienced the reporting process as inseparable from the act of telling itself. What followed disclosure fundamentally reshaped its meaning, transforming it from

a private therapeutic communication into a high-stakes event with relational, legal and public consequences. For participants, disclosure therefore functioned as a journey set in motion by telling, rather than a discrete moment that ended once information was shared.

For the ten participants, this ‘high-stakes journey of disclosure’ began with an active decision-making process, where participants actively considered and thought about whom, why and what they were willing to share about their abuse experience in therapy. Then came the shock of mandated reporting, which was unexpected and surprising for most participants, regardless of how prepared or experienced they were or thought they were. The suddenness of this shock, along with fear of mandatory reporting, had the power to resurrect past fears and terrors, creating a challenging experience in which participants' vulnerabilities were at the forefront. Next on the journey was reporting as a relational event that harmed or healed. The depth of participants' connection with their therapist, along with the therapist's skills, attitude, and ability to navigate the reporting process, played a crucial role in shaping participants' experiences and meaning-making. This pivotal factor could either exacerbate past trauma, as a re-traumatising experience or lead to a transformative experience. Finally, attempting to exercise agency under constraint illustrates how participants responded to the burden imposed on adult survivors by mandated reporting laws and how they found ways to do so within this context. This stage links back to the first, which involved active decision-making, and demonstrates how participants' attempts to re-establish autonomy that had been compromised during the reporting process.

This chapter aims to explore five pivotal issues in reporting arising from this study's findings. Firstly, the four stages in the ‘high stakes journey of disclosure’ (detailed above) will be discussed individually, with reference to existing research and established clinical practice.

The fifth issue will theoretically contextualise these findings within the framework of self-determination theory (Ryan & Deci, 2017) and trauma-informed care (Herman, 1992; SAMHSA, 2014) to enhance professional understanding and practice in the field. Each of these issues will now be considered in turn.

Disclosure as an Active Decision-Making Process

Participants in this study shared their experiences of navigating the disclosure of their abuse to their therapist, which triggered the mandated reporting. One of the interesting findings from this study was that, for all of the participants, their motivation for attending therapy was because things had reached a crisis point for them; as Anne said, "*I can't take it anymore " or for Helen, who reported that "my life was imploding",* and not explicitly their childhood abuse. They described struggling in day-to-day life with mental health symptoms, such as depression, anxiety, eating disorders, flashbacks, post-traumatic stress disorder and suicidal ideation, and these were their reasons for attending therapy. However, while the motivations for attending therapy align for all participants, the underlying causes of their symptoms may differ, stemming from their experiences of childhood abuse. Several studies cite these as common reasons for adults to seek support from psychotherapy (Cuijpers et al., 2021; Grenon et al., 2017; Koenigsberg, 2021; Markowitz, 2017). So, based on the reason for attending therapy, adult survivors appear no different from other adults seeking support from psychotherapy. However, although their reason for attending may be the same, the cause of their symptoms may be different and rooted in their childhood experiences of abuse. Several studies have shown that those who experience childhood abuse are most likely to experience an array of psychological and physical symptoms in adult life (Kendler et al., 2000; MacMillan et al., 2001; Widom, 1999; Wise et al., 2001), thus bringing them to therapy more

often. Having an understanding of these similarities and differences for adult survivors is noteworthy to psychotherapy practice in light of mandatory reporting. Therapists might often be in a position to outline and explain the limits of confidentiality and their role as mandated reporters without knowing that the client has a history of abuse that may be impacted by their mandated role.

In this study, a notable observation emerged regarding participants' disclosure experiences: for many, this was their first time telling about their abuse, their first disclosure, which was intentional and reflective of their decision-making process. This finding presents a marked divergence from established literature concerning adult disclosures of abuse, which posits that such disclosures typically manifest as a process marked by partial or ambiguous disclosures (Alaggia, 2004). Existing research often frames these disclosures as tentative and ongoing (McElvaney, 2015), frequently unfolding incrementally over an extended duration (Ullman, 2010; Wijma et al., 2007). In her examination of the phenomenon of delayed disclosure in cases of child sexual abuse, McElvaney (2015) asserts that partial disclosures are normative rather than exceptional, highlighting the survivors' strategic efforts to preserve their safety and exert control over their narratives. The juxtaposition of the established literature and this study's findings is particularly intriguing. Participants in this study recounted their disclosures as a proactive strategy aimed at reclaiming agency over the impact of their childhood abuse on their daily lives, thus challenging the prevailing assumptions regarding the nature of disclosure in this context. One potential explanation for the observed difference may lie in methodological variations. Most existing studies on the disclosure and delayed reporting of child abuse primarily involve children, adolescents, and sometimes adult survivors recalling their childhood experiences. These studies typically focus on whom the victim chose to tell, when and why, and

detail how, as children and adolescents, they made these decisions and the factors that influenced those choices, based on a child's decision-making processes. However, as Alaggia (2010) highlights, recounting past events is subject to memory loss, revision, and distortion. In contrast, the present study exclusively examines adults who made more recent disclosed decisions specifically in a therapeutic context and subsequently encountered mandated reporting requirements, based on an adult's decision-making processes. It is plausible that the motivations underlying participants' decisions to disclose in this study differ from those being recalled in prior research, along with the differences in decision-making processes, reflecting distinct psychological, social, or contextual factors that influence choices of adults and children.

In the sub-theme *'Finding Someone to Tell',* some participants described actively searching for an experienced therapist who had, as Alma said, *"so much knowledge"*. This behaviour of actively seeking an experienced therapist or 'shopping around' for a therapist (American Psychological Society, 2024) is consistent with the existing literature, which highlights how adults actively seek out experienced or trauma-informed therapists before disclosing childhood abuse. In McElvaney et al.'s (2012) qualitative study exploring delayed and non-disclosure of childhood sexual abuse, with 36 young people and their parents, it is posited that the process of seeking an experienced therapist should be conceptualised not merely as an isolated variable, but rather in the context of broader constructs such as help-seeking behaviour, safety appraisal, and readiness to disclose. This perspective aligns with the findings presented in this study and is also relevant to participants who may not have had a direct role in selecting their therapist. Perhaps they, too, assess the safety within the early stages of the therapeutic relationship. As exemplified by Rebecca's reflections following her initial session, she noted,

"*she made me feel quite safe".* This underscores the significance of perceived safety in establishing a therapeutic alliance, irrespective of the initial therapist selection process.

One of the unexpected findings from this study highlighted how clients openly communicated their need and desire to withhold the truth about their experiences of abuse from their therapists. This decision often emerged as a strategy to avoid mandated reporting, which they feared could lead to further distress for themselves and their families. In some cases, clients even contemplated fabricating details about their abusers; as one client, Anne, expressed, *"I'd make something up".* This trend was notably observed in the case of Sophia, who exemplified this pattern of withholding information in therapeutic settings. From the very beginning of her therapy, Sophia was clear that she did not want her abuse to be reported and felt significant apprehension about the potential consequences for both herself and her family should that happen. Her decision illustrates the complex interplay between coping strategies and self-protection measures that clients may employ during the therapeutic process. It sheds light on how the desire to maintain control over their narratives can significantly impact their willingness to disclose sensitive information. These findings align with recent research conducted by Pellegrini et al. (2023), where Irish psychologists reported knowing that their clients were actively withholding information about their abuse to avoid mandated reporting. Interestingly, the study found that both the therapist and the client were aware that information was being withheld or lied about, but it was not explicitly addressed in therapy. The psychologists involved in this study contextualised the withholding of information as a direct consequence of the mandated reporting requirements. The findings of the current research expand upon existing knowledge and offer distinctive insights into the dynamics of information withholding regarding

experiences of abuse, highlighting that such decisions were primarily driven by the clients themselves, motivated by their need for self-protection and autonomy.

These findings of clients withholding information or lying in therapy are further supported by recent studies, which suggest that clients frequently withhold, distort, or conceal information in psychotherapy, often as a means of self-protection rather than deception (Baumann & Hill, 2015). In the current study, withholding was conceptualised as a means of avoiding mandated reporting, which can be viewed through the lens of self-protection. Studies suggest that such non-disclosure can stem from shame, fear of judgment, mistrust, or concern about the therapist's reaction (Hill et al., 2012; Farber, 2006). Clients may engage in partial truths, omissions, or socially desirable responses to maintain a sense of safety or control within the therapeutic relationship (Hill et al., 2000). In their study with 115 participants, Baumann and Hill (2017) found that between 93–97% of clients admit to concealing significant information during therapy, including issues related to therapy itself, such as dissatisfaction with treatment or discomfort with the therapist. Withholding can also occur when clients are not yet ready to confront painful material, reflecting a protective or avoidant coping mechanism rather than deliberate deceit (Baumann & Hill, 2016).

The findings from this study around withholding or lying about their abuse show a striking similarity with studies exploring clients' intentional withholding of information in therapy because of concerns about potential consequences if they disclose sensitive material such as suicidal thoughts or intentions (Blanchard & Farber, 2017). Previous research indicates that clients at risk of suicide often minimise or conceal the severity of their distress due to stigma, fear of hospitalisation, or a desire to maintain autonomy (Jobes et al., 2018; Hill et al., 2000). Like with mandated reporting, the ethical duty to protect client confidentiality is limited by the

obligation to preserve life, and confidentiality must be breached when there is an imminent risk of serious harm to self or others. This ‘duty to protect’, like the ‘duty to report’, requires therapists to breach confidentiality even if doing so may rupture the therapeutic trust or harm the client. So perhaps it is the consequences of ‘telling’ rather than the ‘telling’ per se that elicits the need to conceal, and it is through this concealment that clients maintain their sense of autonomy.

The Shock of Mandatory Reporting

Further findings from this study illuminate participants' immediate reactions when therapists communicate the necessity of mandated reporting concerning their abuse experience. The data indicate a profound embodied shock response among participants, with Ben articulating this as “*my jaw hitting the floor”.* This study’s findings suggest that participants experienced the shock in embodied, somatic, and physiological ways rather than through cognitive or emotional pathways. To contextualise this finding within the broader framework of existing literature, it is imperative to reference the substantial body of research that investigates shock and its manifestations among trauma survivors. Within the discourse on reporting and psychotherapy clients, there exists a notable absence of detailed exploration regarding this critical aspect. This gap highlights the significant contribution of the current study's findings to the field, emphasising their potential to enrich our understanding and inform future practices.

In contemporary psychological and trauma discourse, shock is conceptualised as an acute psychophysiological state that arises from the confrontation with unexpected, overwhelming, or particularly salient events, thereby exceeding an individual’s immediate cognitive or emotional processing capabilities (American Psychological Association, 2013; Herman, 1992). This conceptual framework resonates strongly with the experiences reported by participants in the

present study, wherein each participant conveyed an immediate reaction to the unexpected introduction of mandated reporting requirements. The narratives articulated by participants suggest that the experience of shock stemmed from the unexpectedness and surprise of the implementation of mandatory, which may have been overwhelming for some. However, the findings present a nuanced contradiction; while shock is typically characterised as a response to unforeseen events, a number of participants possessed prior knowledge of mandated reporting. Some participants were mandated reporters in their professional roles, while others had anticipated this requirement coming up in the therapeutic process and thought about different strategies for managing it. One potential explanation for this contradiction can be found in the pioneering research of Bessel van der Kolk (2014; 1996), whose contributions have been critical in advancing the understanding that trauma transcends mere cognitive or emotional experiences; it is fundamentally entrenched in the body and the nervous system. Through a synthesis of clinical observations and neurobiological studies, van der Kolk illustrated that traumatic experiences—particularly those stemming from childhood abuse—can disrupt brain regions responsible for threat assessment, emotional regulation, and self-awareness (Van de Kolk, 2005;2009). This disruption can result in enduring physiological dysregulation long after the traumatic event has occurred. A central aspect of van der Kolk's work is his reclassification of shock and dissociation as adaptive survival mechanisms rather than pathological symptoms. He posited that in situations of profound or inescapable threat, the brain may inhibit higher-order cognitive processing and conscious emotional responses (van der Kolk, 2014). Consequently, individuals may experience states of numbing, detachment, or shutdown, which serve as a protective function during the trauma itself.

The concept that higher-order cognitive processes—such as reasoning, executive functioning, and judgment—may be inhibited in the face of shock offers a valuable perspective on the observed ineffectiveness of participants' existing knowledge, experiences, and understandings regarding mandatory reporting in modulating their shock response, in this study. As it may suggest, the therapist's communication regarding the necessity of a mandatory report may have been perceived by participants as a profound or inescapable threat. Consequently, this perception could have activated their adaptive survival mechanisms, thereby restricting access to cognitive processing. As a result, participants may have found themselves temporarily deprived of the crucial knowledge that would have otherwise mitigated their shock response.

The complexity of understanding the interplay between physiological responses and psychological processing in therapeutic settings is further highlighted by participants' articulation of their experiences of "*Feeling Fear and Terror from Past and Present"* in response to the introduction of mandated reporting. This finding provides considerable insight and enhances our understanding of clients' reactions to mandated reporting practices during therapy, once the immediate shock response has subsided, through a calming of the nervous system (Ogden et al., 2006). Some previous studies have focused on clients' experiences, such as those by Chouliara et al. (2011) and Kelleher et al. (2012), and they identified that anger and fear were common emotional responses experienced in relation to reporting; however, details of the sources or triggers of these emotional responses were not thoroughly examined in these studies. In contrast, the current study's findings provide detailed insights into the specific fears and triggers described by participants, illustrating how these fears may have been activated in the present or triggered and re-emerged from the past, or a combination of the two. For example, Ben described the complexity of his delayed response, how it emerged in the present as a feeling of "*trembling*

...anger" triggered by realising a report was going to be made. But it was with time (which is in contrast to the immediacy of the shock described above) and with self-awareness and reflection, Ben discovered that beneath this *'trembling .. anger"* was a *"child's fear"* that his abuse was going to be exposed. A moment of terror from his childhood concerning his abuser, which was triggered and brought into the present by the mandated report.

Moreover, while the emotional ramifications of the reporting process on therapy clients have been alluded to in the literature (in studies exploring therapists' perceptions), these observations frequently lack the necessary depth and specificity. For example, Pellegrini et al. (2022) identified a spectrum of emotional responses—including fear, anger, and sadness—experienced by clients in relation to the reporting process, whereas McTavish et al. (2019) highlighted the anxieties that clients face regarding mandatory reporting. The current study supports these findings and also adds to them by contributing a more nuanced understanding of the emotional complexities involved, how the fear and terror about mandatory reporting exposing the abuse can be both past and present, and sometimes experienced simultaneously. In Ben's account, anger was the present response, and the past's was a *"child fear"*. This narrative exemplifies the intricate interplay between historical and contemporary fears, thereby illuminating the multifaceted nature of fear and terror encountered by clients within therapeutic contexts, when confronted with mandatory reporting.

An intriguing aspect of the findings from this study pertains to the catalysts for the emotive responses described by participants. Specifically, the act of learning about mandated reporting was experienced as a significant loss of control, which one participant, Helen, evocatively described as akin to *"a runaway train"*. Inka described it as trying to catch a *"a roll of tread"*. This mention of reporting seemed to evoke a profound and familiar sentiment among

participants—an intersection of diminished power in the present along with a resurgence of echoes from their past, particularly as it relates to childhood trauma. For Anne, the diminished sense of control in the present elicited a profound emotional response. She articulated her apprehension by stating that she feared *"the SWAT team is going to arrive at the door".* This overwhelming present fear may be attributed to the absence of any identifiable past triggers, which could stem from Anne's significantly limited conscious recollections of her childhood trauma, which led her to question if she had been abused as a child. Consequently, the affective responses associated with her past experiences, which remained unconscious, may have been transposed onto her current conscious fears, exacerbating her anxiety in the present moment.

While the existing body of literature addressing mandated reporting in psychotherapy touches upon the emotional responses elicited by such practices, it insufficiently explores the underlying triggers. The findings of this study, however, underscore the need to focus on the origins of these triggers (if present and possible), which can be starkly different to the surface emotions for some participants, such as Ben. The significance of addressing emotional responses in the therapeutic context is paramount for both clients and therapists. For clients, engaging with the intricacies of their reactions to the reporting process allows them to gain a deeper understanding and awareness of the triggers that influence their emotional state. This awareness is crucial in developing effective strategies for managing these responses. For therapists, comprehending the full scope of a client's experiences enhances their ability to tailor their interventions appropriately. For instance, the therapeutic approaches required to address anger markedly differ from those designed to confront a child's fear. This nuanced understanding enables therapists to provide more effective support, fostering a productive therapeutic environment that addresses clients' unique emotional landscapes.

Participants also articulated their experiences and the emotional ramifications associated with awaiting feedback from Tusla or the Gardaí regarding their reports. Several participants expressed anxiety about the outcome of the reporting process and the potential consequences that might ensue. Sophia said, *"it was stressful… not knowing".* This finding aligns with the limited existing literature on the experiences of mandatory reporting. In their meta-analysis, McTavish et al. (2019) examined 35 studies addressing the experiences of children and their caregivers regarding mandatory reporting. The majority of the studies focused on pregnant women or mothers who were experiencing substance misuse or were subjected to intimate partner violence, and these were the risks that prompted a mandated report. The analysis revealed that participants often harboured fears about the outcome of the reporting process – the response from the CPS. The present study contributes to and expands upon this understanding of fear by incorporating concerns regarding the repercussions following the report from a different cohort of participants. Furthermore, a recent Irish study conducted by Mooney (2021) investigated the experiences of five adults as they disclosed their abuse histories directly to Tusla. The findings indicated that these participants encountered considerable delays in responses, ineffective communication, and a lack of clarity throughout the process, all of which contributed to heightened stress and re-traumatisation. Findings from the current study support the findings from Mooney's (2021) study. Rebecca poignantly expressed how her interactions with Tusla following the mandated report left her feeling *"failed and let down".*

When Reporting Becomes a Relational Event That Harms or Heals

In the wake of the initial shock that mandatory reporting prompted, participants faced a wave of fear and anxiety stemming from both their past and present experiences. As they

navigated the reporting process, the therapeutic relationship became increasingly pivotal. Participants noted this phase as a crucial turning point, where the quality of interpersonal connections and the dynamics of cooperation significantly shaped their experiences. The influence of their therapists emerged as a decisive factor; for many, the therapist's approach either mitigated distress or exacerbated it. Participants highlighted how certain attitudes, behaviours, and interpersonal skills exhibited by their therapists could turn the reporting process from a potentially re-traumatising ordeal into a transformative journey. The continuum of experiences underscored the profound impact of a supportive, empathetic therapeutic relationship, illustrating that differences in reporting outcomes often hinged on these critical relational elements. Ultimately, the experience of mandatory reporting was less about the act itself and more about how it was navigated through the lens of the therapeutic alliance.

The current study identifies four key dimensions that influence the fulcrum of this continuum, each of which will be critically examined in relation to the existing literature. The first dimension is the '*strength of the connection'.* Participants in this study underscored several qualities that enhanced their relationship with their therapists; notably, feelings of comfort, respect and care emerged as significant factors. Participants reported that their therapists demonstrated these attributes through consistent actions, such as teaching symptom-management techniques. For all participants, a key element that strengthened the therapeutic relationship was the felt experience that they mattered to their therapist. Participants emphasised the importance of feeling cared for, and how their therapist demonstrated this by prioritising their well-being above the therapist's legal obligations as mandated reporters. This dynamic fostered a greater sense of trust and safety within the therapeutic context. Alma articulates this sentiment when she states, *"it's a human here that maybe needed a little bit of time",* noting that her therapist's

willingness to provide her with that time was *"massive ... massive"*. This illustrates the significant impact that the therapist's compassion, understanding and recognising the client as first and foremost a survivor of abuse, can have on the therapeutic process.

To situate these contributions within the existing body of literature, it is important to acknowledge that prior research has proposed that mandated reporting should be conceptualised as a relational process rather than merely a procedural obligation (Steinberg et al., 1997; Strozier et al., 2005; Weinstein et al., 2001). Earlier studies have hinted at this notion, underscoring the significance of the therapeutic alliance in influencing the outcomes associated with mandated reporting experiences (Watson et al., 2912). For example, Weinstein et al. (2001), in their qualitative survey study centred on mandated reporters, posited that the act of reporting ought to be understood as a relational dynamic instead of solely a legal duty. They identified several factors that contribute to positive outcomes, including the duration of therapy preceding the report and the quality of the therapeutic relationship, without venturing into any further details about these qualities. The findings of the current study significantly enhance this body of research in two principal ways: firstly, by elevating the voices and lived experiences of psychotherapy clients, and secondly, by delineating the essential elements that psychotherapy clients seek from their therapists when the subject of mandated reporting arises, such as a supportive relationship grounded in care. The unpublished research undertaken by Rokop (2003) involved psychotherapy clients who were identified as perpetrators in reports submitted by mandated reporters, provides additional support for the proposition that a therapist's actions and behaviours significantly influence a client's experience of the reporting process. Furthermore, it has been the only study found to posit that the therapist's influence on the client's reporting experience is more substantial than any other factors. This assertion highlights the critical role

therapists play in shaping the therapeutic environment and the overall client experience, which is supported by the findings from the current study. It is important to highlight that these studies (the current study and Kokop, 2003) were conducted with psychotherapy clients rather than therapists, previous research exploring therapists' experiences did not find similar results. This distinction perhaps suggests that research involving therapists may possess inherent blind spots or biases, potentially limiting their ability to fully recognise the significance of their impact on clients' reporting experiences.

The findings from this study stand in contrast to those of another study examining clients' experiences. Kelleher et al. (2012) conducted research with six Australian women participating in a residential intervention program for families reported to the CPS, where the parent was the reported abuser and the person in therapy who participated in the study. Their findings revealed that the participants experienced a conflict between the positive feelings they developed toward their therapists and the negative sentiments associated with their role as mandated reporters. This nuance was also indirectly highlighted in Rokop's (2003) study on client characteristics, which identified factors leading to positive outcomes, which included forgiveness of the therapist for reporting. Interestingly, in the current study, the majority of participants did not distinguish between their therapists and their roles as reporters. When participants reported a negative relationship with their therapists, they often perceived the therapeutic interactions as more personal. For instance, Sophia remarked that the therapist was *"very much trying to coax it [detail of the abuse] out of me"*, while Grace expressed that she felt her therapist was *"pushing an issue"* to ascertain the truth of her statements. Inka's experience was more direct; her therapist was minimising and disbelieving about her abuse, calling it *"sibling rivalry"*. A possible explanation for this difference may be in the cohort of participants. In the Rokop study, the

mandated report was made against the participants, whereas in this study, the participants' abuse was being reported. So perhaps it was more personal when the participant's abuse was the focus of the mandated report.

Numerous studies have examined both beneficial and detrimental events in therapeutic settings, as detailed in the literature review section on psychotherapy. A notable study by Park et al. (2025), conducted in the United States, employed thematic analysis to scrutinise 224 recorded therapy sessions involving young clients, delivered by 92 therapists, with the aim of identifying errors within therapeutic interactions. The findings revealed that confrontational behaviours exhibited by therapists, characterised by disbelief or expressions of doubt, prove particularly harmful to clients and undermine the therapeutic alliance, as was the case in the findings from the current study.

The existing literature on the coercive application of mandatory reporting practices is limited and outdated. A seminal study conducted by Anderson et al. (1993) involved qualitative interviews with 30 therapists and 25 child protection workers, which revealed that certain therapists utilised mandatory reporting as a coercive tool. These therapists leveraged the threat of reporting to compel client attendance in therapy sessions and to encourage active engagement in treatment. While one might assume that such practices are now deemed unethical and, consequently, nonexistent in contemporary society, with the establishment of professional bodies for psychotherapists and the codes of ethics informing clinical practice, the findings from the current study indicate otherwise, with 30% of participants reporting such experiences, contributing to their experience of reporting as re-traumatising.

The final observation to be examined is articulated by Sophia, who perceived her therapist as *"coaxing"* information from her. This experience aligns with findings from a quantitative study conducted by Brown and Strozier (2004), which surveyed 52 family therapists across the United States. The study suggests that, when confronted with the necessity of a mandated report, therapists often redirect their focus onto the reporting process, potentially undermining the therapeutic process and its associated issues. It is possible that this shift in the therapist's behaviour following the need to report was what Alma was expecting from her therapist (as discussed above); however, the actual experience was the opposite, with the therapist prioritising her needs, which ultimately strengthened their therapeutic relationship.

The second key dimension that significantly influenced the relational fulcrum and, therefore, participants' experiences of the mandatory reporting process was the necessity for guidance. As the focus of the reporting procedure was a novel experience for all study participants, they lacked familiarity with its requirements and anticipated outcomes. Consequently, this prevailing uncertainty elicited feelings of *"powerlessness"* as articulated by Ben, reflecting a combination of both past and present emotional responses. The current findings suggest that to help manage these feelings, participants searched for answers and looked to their therapists as essential sources of information and support crucial for navigating the complexities of the reporting process. When therapists adequately addressed this need, participants reported feeling *"more in control"* and experiencing *"more autonomy",* as articulated by Rebecca. This enhanced sense of agency contributed to a more transformative therapeutic experience. Such findings align with existing literature on mandatory reporting and psychotherapy. For instance, in a qualitative study conducted by Chouliara et al. (2011) involving Scottish therapists and adult

survivors of childhood abuse, survivor participants characterised the reporting process as "scary" (p. 145). However, they reported feeling more empowered when their therapists provided a detailed explanation of the process and its implications, mirroring the experiences of participants in the current study. Furthermore, Rokop (2003) highlighted the importance of therapists providing "supplementary support" as a key attribute that positively influences therapeutic outcomes. The findings of the current study also contribute to this existing body of knowledge regarding the therapeutic process and its impact on disclosures of childhood abuse. The data suggest that when therapists effectively meet the participants' need for guidance, it results in a greater sense of empowerment among participants. This empowerment is crucial in fostering their confidence to perhaps disclose previously withheld accounts of childhood abuse. As articulated by Helen, who stated, "*okay, now I am comfortable [to report the other perpetrators]",* the significant role of the therapist is underscored. This highlights not only the importance of ensuring a positive experience with mandatory reporting but also emphasises the therapist's critical role in the ongoing protection of children from abuse by creating safe environments for adult survivors of childhood abuse to feel safe enough to begin to disclose their abuse experiences.

The current study extends previous research by examining the adverse effects of insufficient therapeutic guidance, particularly when therapists fail to provide information or provide inaccurate information. Anne recounted her experience of receiving misinformation and untruths from her therapist, which exacerbated her fear and rendered her experience of mandatory reporting considerably more distressing. The repercussions of such deficits, specifically the absence of essential support and guidance from therapists, have not been adequately addressed in the existing literature. Notably, Kokop (2003) highlights that

psychotherapy clients may perceive their therapists as lacking experience, suggesting that this inadequacy may contribute to negative therapeutic outcomes, although the study does not specifically discuss the provision of information, or lack thereof.

Moving now to consider the third key dimension in the relational fulcrum of participants' experience in mandatory reporting, *'power being re-balanced'.* All therapeutic relationships feature a power differential, with therapists holding professional authority over diagnoses, treatments, and the overall structure of therapy (Green, 2015), whilst clients often come in vulnerable and in need (Proctor, 2021; Boyd, 1996). While this power imbalance is not inherently unethical, it becomes problematic when unacknowledged, undermining client autonomy and trust (Proctor, 2021). Unexamined power dynamics on the part of the therapist can prioritise their interpretations over their clients' lived experiences, reinforcing hierarchies (Williams & O'Connor, 2019). Clients from marginalised or vulnerable backgrounds may face exacerbated imbalances due to intersecting social and cultural inequities (Proctor, 2021), as may be the case for adult survivors of childhood abuse. To address these issues, contemporary ethical frameworks promote transparency, collaboration, and reflexivity to create a more equitable therapeutic alliance (Boyd, 1996) (as discussed in Chapter Two – section on ethical codes).

In the current study, many participants expressed awareness of the power imbalances inherent in therapeutic settings, particularly when compounded by mandatory reporting. This legal obligation significantly alters the role of the therapist, who assumes the responsibilities of a mandated reporter. This aligns with Foucault's (1982) argument that power is relational and not possessed. The power of a therapist, therefore, emerges in how others respond to this authority. Therefore, how and to what extent therapists acknowledge and navigate these power dynamics

profoundly affects participants' experiences of mandatory reporting, which can be perceived as either re-traumatising or transformative. The parallels between the inherent power imbalances in therapy and those present in the dynamics between perpetrators and adult survivors of childhood abuse have been extensively documented in the literature (Harper & Steadman, 2003; Herman, 1998; Levy, 1998; Palmer et al., 2001). However, these dynamics are accentuated in the context of mandatory reporting, as it introduces a legal framework that not only reinforces the therapist's authority but also amplifies their power within the therapeutic relationship. This intersection of legal obligation and therapeutic responsibility necessitates a nuanced understanding of how power shapes both the therapeutic process and survivors' experiences.

Participants reported how being given time and space (before the reporting process) to recover from the shock of reporting and to process the idea of reporting helped, as they did not feel pressured or overwhelmed by what needed to be done. Rebecca felt *"I could have a bit more time",* which allowed her to continue with therapy, something she initially did not think she would do. This also highlights that time is necessary for the high-level neurological functioning to return after the shock response (as discussed above), and the importance of a therapist prioritising this. The findings from the current study demonstrate that, as the therapist negotiates their obligation to report with the needs of the participants, they attempt to rebalance this power, making it more collaborative. This finding contributes to the existing body of literature regarding the intersection of power dynamics and psychotherapy, particularly highlighting a notable gap in the mandatory reporting discourse. An insightful study relevant to this inquiry is an unpublished doctoral dissertation by Day (2010), which examined the construct of power within the therapeutic relationship through the lens of nine experienced therapists. The study revealed that effective negotiation of power between the therapist and the client is essential for fostering a

collaborative power dynamic. The current findings reinforce this collaborative approach, which James described as recounted, *"we did it together"*, which aligns with principles of trauma-informed care (refer to Appendix S and the subsequent section). Such an environment cultivates safety within the therapeutic relationship, thereby empowering clients, as evidenced by Helen's experience, where she described feeling emboldened enough to *"unstopper my mouth"* and more fully share her abuse experiences.

At the opposite end of the continuum, some participants perceived that the reporting process exacerbated power differentials. This was interpreted as a diminished sense of agency, voice, and collaborative engagement. In Sophia's situation, the therapist leveraged her professional role and legal obligation as a mandated reporter, thereby reinforcing a hierarchical power dynamic over Sophia. Sophia recounted that the therapist stated, "*It's my role",* while presenting her with the completed forms, highlighting the imposition of authority in the reporting process. Her therapist also saying "*it is not my choice"* might suggest that the therapist herself felt the power and weight of the reporting requirements, which she may have transferred onto Sophia, as countertransference. Such a possibility would support De Varis's (1994) argument that the counter-transferential material of the therapists can either enhance or hinder the therapeutic process, thereby underscoring the significance of counter-transferential dynamics within the therapeutic relationship, highlighting the importance of therapists using reflective practice and supervision to work through these counter-transferential issues (Bernard & Goodyear, 2019).

The fourth and final key dimension of the relational fulcrum pertains to participants confronting what reporting opens up for them. For many, this process became a re-traumatising event, manifested as a profound sense of betrayal that affected them on personal and relational

levels. The therapeutic trust fostered between participants and their therapists was significantly undermined by the reporting and experienced as a betrayal, encapsulated in Inka's poignant remark, *"I thought I could trust you".* The betrayal is felt relationally; it is the therapist and not the reporting process that has betrayed them. This pervasive experience of betrayal corroborates findings from prior studies examining mandatory reporting within the context of psychotherapy (Crowe & Dare, 1998; Kelleher et al., 2012). Havig (2008), in a systematic review, found that the formalised nature of mandatory reporting exacerbates feelings of vulnerability and powerlessness, links that echo past traumas. In Pellegrini et al.'s (2022) study, findings suggest that the psychologists surveyed conceptualised this betrayal as a resurgence of the powerlessness experienced by adult survivors during their abusive encounters. Ben's experience supports this conceptualisation when he articulated that therapists *"are being made quasi-abusers"* by the reporting process*,* and he felt that he was *"screwed all over again",* which he describes as being forced to do something he does not want to do. In Pellegrini (2022), psychologists also shared how they felt they were taking the place of their clients' abusers, causing harm due to making the mandated reporting. Sweeney et al. (2018) elucidate that specific practices prevalent in mental health settings can unintentionally re-traumatise individuals, particularly those who are survivors of interpersonal trauma, by echoing previous coercive experiences. In a complementary vein, Kimberg and Wheeler (2019) examined how historical traumas often stem from breaches of power and trust. Consequently, when healthcare practices inadvertently mimic these coercive dynamics, they can evoke a sense of threat. The findings from the current study lend support for these studies when healthcare practices include mandatory reporting (which is the case in some jurisdictions, like Ireland).

However, mandatory reporting does not always result in re-traumatisation; it can have positive impacts. McTavish et al. (2017), in their meta-analysis, found that 75% of mandated reporters held negative views, while only 25% viewed it positively. Alvarez (2005) noted that reporting is not always harmful, and Watson & Levin (1989) identified a positive outcome when children continued therapy post-report. Weinstein et al. (2000) reported that 73% of mental health professionals observed positive changes related to report timing and therapeutic relationships.

In the current study, not all participants experienced the reporting of their childhood abuse as a betrayal, which opened a space for alternative, more transformative experiences of mandatory reporting. For Helen, her experience with reporting helped her find distance from her abuse and abusers that allowed her to *"help herself to flourish"*. For James, he found the courage, through the reporting, to accuse his abuser, something he wasn't able to do as a young adult and finally, for Alma, she was able to use the reporting process to try and put a stop to a pattern of generational abuse in her family as a way to protect her own children. These findings, although limited, are very powerful and suggest that, where possible, experiences with reporting can bring transformational changes to participants' lives.

Exercising Agency Under Constraint

The final stage on the 'high stakes journey of disclosure' involves participants finding ways to exercise their agency. Despite the significant burden imposed by mandatory reporting, participants' accounts reveal that they were not passive in the reporting process. Instead, participants described various ways of exercising agency within an imposed process, seeking to act, adapt, and make meaning despite limited control. The findings from this study suggest that

participants exercised their agency in two significant ways. The first involved *'confronting reality'.* Under the current mandatory reporting regulations in Ireland, which have undergone revisions twice throughout the course of this study (refer to Chapter Two for a detailed examination of the changes to Irish legislation), a retrospective mandated report must be submitted to Tusla when an adult survivor of childhood abuse discloses such experiences, but only if there is a current risk to potential children posed by the abuser. To ascertain the presence of such a risk, therapists now need to discuss this possibility with their clients. This obligation requires clients to consider the potential for others to be at risk. A consideration that many participants in the current study reported to only have had to confront as part of mandatory reporting. For many participants, the notion presented by the therapist was not one that had been actively contemplated prior to this discussion; it was only upon the therapist's prompting that these thoughts emerged. This scenario proved challenging for the participants and likely would not have been navigated without the therapist's guidance. James articulated this experience as *"being forced to think about it",* while Inka described it as the therapist *"putting new thoughts in my head"*. Upon the introduction of these concepts, some participants embraced them almost immediately, whereas others required additional time for contemplation. The limited research on mandatory reporting and psychotherapy does not address this concept of confronting reality. However, there is an extensive body of research investigating abuse and abuse disclosure, which sheds light on these findings.

The findings of this study align with existing literature, which indicates that both children and adult survivors of abuse frequently adopt self-protective strategies to alleviate feelings of distress, guilt, and fear (McElvaney, 2015). These strategies are widely recognised as adaptive responses, particularly in contexts such as abuse that are characterised by powerlessness.

Common survival strategies include psychological distancing (Herman, 1992; Kross & Ayduk, 2011) and compartmentalisation (Herman, 1998; van der Kolk, 2014), which serve to create a necessary emotional separation from the trauma of abuse while enabling individuals to maintain functionality in their daily lives, and perhaps explains why the participants in this study had not considered the possible of others being at risk prior to the therapist bring it into the therapeutic relationship.

Extensive literature examining the reasons behind delayed disclosure of abuse by both children and adults highlights that feelings of guilt and shame represent significant barriers to disclosure (Alaggia et al., 2017; Ettinger et al., 2022; McElvaney, 2015). These emotions, often perceived again as adaptive control mechanisms, reflect a tendency among survivors of abuse to internalise responsibility for the abuse. This internalisation manifests as self-blame and guilt, which, paradoxically, may provide a semblance of control over an overwhelmingly chaotic situation. The complexities of guilt and shame thus emerge not only as psychological burdens but also as protective strategies that facilitate coping in the aftermath of trauma (London et al., 2005; McElvany, 2015; Paine & Hanen, 2002). The aforementioned findings indicate that participants often fail to confront the reality of the harm inflicted on others by their abuser. This observation reinforces the notion that individuals bear a significant sense of internalised guilt regarding their own culpability in the abuse. Consequently, this internalisation may diminish their capacity to recognise others' potential for harm. Such a dynamic suggests a complicated interplay between personal accountability and the acknowledgement of external consequences.

Some of the participants in the study had a need for more substantive engagement from their therapists, rather than just a discussion about the possible risk to others, before they could consider the possibility. They required a new framework for understanding their experiences of

abuse, and it was only when their therapist framed their abuse as a criminal act that new opportunities for processing emerged, as Rebecca said, "*these crimes were committed against me…and that's huge".* This finding can be further elucidated in accordance with the explanations provided above, around guilt and shame and adaptive strategies. Additionally, another potential interpretation is based on contemporary trauma-informed therapies such as cognitive processing therapy (CPT) (Resick et al., 2002), eye movement desensitisation and reprocessing (EMDR) (Shapiro, 1989), and trauma-focused CBT (Cohen et al., 2006). These therapies facilitate recovery by re-processing trauma-related beliefs that were formed in the context of threat and survival. Through this process, survivors can examine and revise rigid, survival-based assumptions about safety, responsibility, and self-worth that are no longer adaptive in the present. As these beliefs are updated, traumatic experiences can be more fully integrated, leading to reductions in guilt, shame, and persistent trauma symptoms (Herman, 1992; Resick & Schnicke, 1992; Resick et al., 2017). In offering alternative explanations for participants' experiences of abuse, as seen in this study, such as 'it's a crime', therapists may have facilitated a reframing of the participants' rigid self-beliefs and narratives surrounding their trauma. This cognitive restructuring is significant as it opens up the possibility for participants to consider that others might have been harmed. As participants began to entertain this possibility, they may have gained varying degrees of agency in their decision-making processes, leading to a more empowered stance in their lives.

The second way in which participants used their agency was in addressing the burden of responsibility that mandatory reporting placed on adult survivors of abuse. All participants, to varying degrees, carried the burden of responsibility for other actual or potential abuse victims.

They each found a unique and personal way to discharge or carry this responsibility. For Grace, she found the agency to go directly to the parent of the child she felt was at risk and, later, with the mandatory reporting, to discharge or hand over the responsibility she had been carrying for years. She described this moment as *"revolutionary to walk away from feeling responsible"*. This finding supports the existing literature on the purpose and design of mandatory reporting frameworks. For instance, Mathews (2015) and Mathews et al. (2014) articulate that mandatory reporting statutes are fundamentally designed to shift the onus of child protection from children—along with adult survivors—to responsible adults and statutory systems. They emphasise that it is unreasonable to expect children and adult survivors to safeguard themselves or to disclose instances of abuse in a secure manner. By establishing a legal obligation for professionals to report suspicions of harm, mandatory reporting aims to ensure that the responsibility for safeguarding rests with trained adults and child protection authorities, rather than with the child survivor. This perspective is corroborated by the current study's findings, particularly as illustrated by Grace's experience.

Recent findings from the current study illuminate that the implementation of mandated reporting processes does not consistently function as intended. In specific contexts, such processes can inadvertently cause harm, particularly when the primary objective is protecting vulnerable individuals. This observation aligns with the research by Schwab-Reece et al. (2022), which underscores that although mandated reporting aims to alleviate the burdens on survivors—especially children—and to secure their protection through statutory systems, the transfer of responsibility is not universally perceived as beneficial or safe. Several participants shared their experiences with mandated reporting as a way of passing responsibility to Tusla, but the

responsibility was not accepted, and in some cases, participants experienced that as returning the responsibility to them, due to perceived inadequacies in the information they provided. This refusal to accept responsibility was described as exacerbating feelings of guilt, as illustrated by Anne's poignant reflection: *"I felt guilty… and I haven't done anything wrong."* For Rebecca, this experience extended beyond the confines of guilt; it embodied a forced relinquishment of responsibility that she felt compelled to accept yet found insurmountable to cope with. This situation proved to be excruciating, as she grappled with the unsettling awareness that children might remain at risk amid ongoing inaction. Using her agency, she developed a coping mechanism to navigate this distressing reality, articulating, *"it's the one part I have to suppress… because it's too much."*

The actions of participants in the present study do not undermine the efficacy of the mandated system; rather, they reflect concerted efforts to reclaim influence within it. Recognising the reclamation of agency in constrained circumstances constitutes a significant contribution to the field, as it challenges prevailing assumptions that mandatory reporting inherently renders survivors passive or devoid of power. The findings indicate that even minimal opportunities for choice and meaning-making can yield considerable psychological benefits, particularly for individuals whose previous experiences of abuse involved a profound loss of control. Consequently, supporting agency within the constraints of mandated systems may serve to mitigate the risks of re-traumatisation while fostering engagement and resilience. This underscores the clinical significance of therapeutic practices that prioritise the preservation and support of agency, even when individuals' autonomy is necessarily restricted.

As exercising agency represents the final stage of the 'high-stakes journey of disclosure,' it can be posited that participants at this stage are endeavouring to regain a sense of autonomy and equilibrium that has been disrupted by the experience of mandatory reporting. This effort reflects a desire to restore their initial agency and autonomy seen at the beginning of the journey in their active decision-making process concerning disclosure; perhaps the journey will always gravitate back to agency and autonomy.

Understanding Survivors' Experiences Through Theoretical Frameworks

This section attempts to interpret the findings of the study through psychological and trauma-informed frameworks to better understand adult survivors of childhood abuse and their experiences with mandatory reporting in therapy. By viewing mandatory reporting beyond a legal obligation, these frameworks analyse survivors' narratives within the relational, emotional, and structural dynamics of therapeutic practice. Utilising Self-Determination Theory of Wellness (SDT) (Ryan & Deci, 2000) and principles of trauma-informed care (TIC) (Herman, 1992; SAMHSA, 2014), this discussion examines how autonomy, safety, and relatedness impact survivors' experiences of disclosure and reporting, offering a nuanced perspective on their reactions as contextually significant responses.

Self-Determination Theory of Wellness

Self-determination theory is defined by its creators as "a psychological theory that goes to the heart of the issues of happiness and human capabilities and deals directly with the ideas of human actualisation and flourishing" (Ryan & Deci, 2017, p.5). It is a theory of both motivation and wellness. The theory maintains that there are at least three basic and universal human

psychological needs: *the need for autonomy,* the desire to feel volitional and to fully endorse one's actions (deCharms, 1968; Deci & Ryan, 1985); *the need for competence,* which is the desire to feel effective in one's interactions with the social and physical environments (Deci, 1975; White, 1959); and *the need for relatedness,* which is the desire to belong, to care for and feel cared for by others (Baumeister & Leary, 1995; Ryan, 1995). When autonomy, competence, and relatedness needs are supported, individuals are more likely to experience both adaptive forms of motivation and psychological integration, whereas sustained need frustration is associated with distress and withdrawal (Ryan & Deci, 2017).

This discussion centres on wellness outcomes since mandatory reporting, as shown in this study, mostly affects individuals' psychological well-being rather than their motivation. SDT conceptualises wellness as the capacity to remain psychologically integrated and agentic within one's environment, even under difficult conditions.

Self-Determination Theory of wellness posits that well-being is fundamentally influenced by the degree to which social environments fulfil individuals' basic psychological needs for autonomy, competence, and relatedness. This framework shifts the focus of psychological distress from an exclusively individual-centric perspective to an understanding that psychological experiences are significantly shaped by situational and relational contexts. These contexts may either facilitate or hinder the satisfaction of the aforementioned needs. When autonomy needs are adequately supported, individuals typically experience a heightened sense of agency and self-endorsement. In circumstances where competence is nurtured, individuals are likely to perceive their environments as more predictable and manageable, thereby enhancing their psychological resilience. Furthermore, when relatedness is reinforced, a sense of safety and connectedness with others is fostered. Conversely, the persistent frustration of these fundamental

needs correlates with psychological distress, withdrawal behaviours, and defensive mechanisms (Vansteenkiste et al., 2006). Thus, SDT redefines wellness not merely as the absence of adversity, but as the presence of conducive conditions that enable individuals to maintain psychological integration and engagement, even amidst constraints.

In the current study, Self-Determination Theory is used as an interpretive framework to understand how participants experienced mandated reporting during therapy. Rather than focusing on behaviour or outcomes, SDT provides a lens for examining how the therapeutic environment and therapist characteristics (skills, attitudes and behaviours) influence survivors' psychological experiences related to autonomy, competence, and relatedness. Autonomy is seen as volition—acting in line with one's values—rather than as complete freedom, which is crucial in situations of external control, such as mandatory reporting (Deci & Ryan, 2008). This legal obligation may limit participants' control over disclosure (autonomy), create uncertainty about consequences (competence), and complicate feelings of safety (relatedness) (Ryan & Deci, 2017). Participants shared distress and adaptive strategies are viewed as responses to threatened psychological needs rather than disengagement. SDT provides practical guidance for therapists, suggesting that they can reduce distress by creating need-supportive environments. Transparency and shared decision-making can promote autonomy (Bonanno & Mancini, 2008; Williams et al., 2014), while clear communication about reporting processes can enhance competence (Deci & Ryan, 2008; Knight, 2015). Additionally, fostering relatedness through emotional attunement is vital (Elliott et al., 2005). These practices are underscored in findings like "*At a Turning Point, Held by the Therapist"*, highlighting how a therapist's skills can either re-traumatise or transform the therapeutic experience. In summary, SDT emphasises structuring therapeutic environments to

reduce distress and support participants' sense of autonomy and competence in constrained systems (Ryan & Deci, 2017).

Trauma-Informed Care

Trauma-informed care (TIC) offers a complementary theoretical lens to Self-Determination theory, addressing relational and institutional dynamics related to trauma. TIC is a strengths-based framework that recognises trauma's widespread impact, promoting environments that foster safety, trust, empowerment, collaboration, and choice (Fallot & Harris, 2009; SAMHSA, 2014). Understanding that trauma often involves powerlessness and loss of control, TIC aims to prevent re-traumatisation by integrating sensitivity to these issues in healthcare delivery (Elliott et al., 2005; Courtois & Ford, 2013).

Rather than adhering to specific techniques, trauma-informed practice reflects a philosophical shift in clinical questions from "What is wrong with you?" to "What happened to you?" (Harris & Fallot, 2001). This reorientation helps situate distress in a context of survival rather than pathology, encouraging empathy and collaboration. Trauma theory posits that overwhelming events compromise an individual's safety, agency, and trust in others (van der Kolk, 2014). Consequently, TIC emphasises rebuilding these capacities through consistent, respectful interactions, guided by the six principles of trauma-informed care (Harris & Fallot, 2001; SAMHSA, 2014). These include safety, collaboration, empowerment, and choice (see Appendix S for details).

A trauma-informed care (TIC) approach is essential in the context of mandatory reporting, as it addresses the relational impacts of reporting practices that extend beyond the act of reporting itself. Participants in the current study reported that mandatory reporting frequently

resulted in a breach of trust, described by some as *"a betrayal"* or *"a second trauma",* particularly when the processes felt abrupt, unclear, or enforced externally. Feelings of exclusion from decision-making and insufficient information about the reporting process diminished their sense of relational safety during vulnerable moments. These experiences could indicate, from a TIC lens, that the challenges may not stem solely from the mandatory reporting process itself, but perhaps from a lack of attention to the relational dynamics that are important to ensure that the psychotherapy client is not re-traumatised by the process (Knight, 2015). Conversely, where participants felt consulted and supported throughout the reporting process, the experience was perceived as less disempowering and sometimes as protective or transformative (Wall & Quadara, 2014). These findings underscore the significance of TIC in mediating the effects of mandatory reporting on well-being. They reinforce the notion that mandated reporting must be carefully considered and carried out to avoid inadvertently perpetuating dynamics of control, silence, or re-traumatisation. Consequently, TIC is vital for interpreting the practical implications of mandatory reporting, not only as a legal obligation but also as a relational intervention with profound effects on agency and psychological well-being.

Considering mandatory reporting during therapy through the combined lenses of Self-Determination theory and trauma-informed care foregrounds its dual character as both a protective mandate and a relational practice with significant implications for wellbeing. SDT draws attention to how mandatory reporting processes impose constraints on participants' basic psychological needs, particularly autonomy and competence, while TIC illuminates the relational and systemic conditions under which reporting may either mitigate or compound trauma. Read together, these frameworks shift the analytic focus away from compliance alone and toward the lived experience of reporting as it is enacted within the therapeutic context. This integrated

perspective underscores that the impact of mandatory reporting is not determined solely by its legal necessity, but by how it is communicated, relationally held, and supported in practice. Framing mandatory reporting in this way allows the findings of this study to contribute to broader debates about child protection, ethical responsibility, and survivor-centred practice, highlighting the importance of approaches that protect safety without undermining agency or psychological well-being.

Conclusion

In summary, taken together, the findings from this study demonstrate that mandatory reporting fundamentally reshapes the experience of disclosure within psychotherapy, transforming it from a personal therapeutic act into a 'high-stakes journey'. Disclosure emerged not as a moment of telling, but as an active and ongoing negotiation shaped by fear, anticipated consequences, and efforts to preserve agency. The initiation of mandatory reporting is met with the immediate, embodied, destabilising response of shock, with the capacity to re-activate past trauma and intensify feelings of powerlessness. At this juncture, the therapeutic relationship functioned as a decisive site of harm or healing, with therapists' transparency, guidance, and handling of power shaping whether the process was experienced as re-traumatising or transformative. Crucially, the findings challenge assumptions that agency is lost once reporting is triggered, showing instead that survivors continue to act, adapt, and make meaning under constraint. The findings are finally considered through the lens of Self-Determination theory and trauma-informed care, which offer a conceptualisation of a profoundly relational and psychological process that demands careful, trauma-informed, and autonomy-supportive therapeutic practice.

Researcher's Reflective Comments:

Putting together the findings chapter has been a challenge. In the beginning, I struggled to showcase the findings and participants' experiences and was more comfortable focusing my writing on the research my findings supported. Working through this and reflecting, I think much of it was hesitation and apprehension about highlighting and promoting the findings because I wasn't confident in what they meant. A member of my supervisory team asked me early on in my writing of the chapter what the key messages of my study were. I struggled to answer this. I could talk about the findings and the GET's, but taking this a step forward and explaining what this meant and why it's important was eluding me. It wasn't until I sat down and tried to tell the story of my findings- what the findings were trying to say?, that the pieces of the jigsaw fell into place for me.

Once I could name the key issues, I worked hard to create some kind of structure. This came about more fully when I found the title 'A high-stakes journey of disclosure', then the issues fell into the four key stages of this journey. Once I had this, the writing of the chapter became easier; I had a structure and a story to tell. This, too, helped me build my confidence, and I began to find the voice that had been so difficult for me at the beginning.

I enjoyed reading about different topics and seeing how the findings support or challenge other research. Some of the findings, like the body of research on concealment in therapy, were a complete surprise to me, so there was much learning for me as a researcher and as a clinician. The final part of the jigsaw fell into place for me when I came across the theory of self-determination, which encapsulated what the participants, in their own unique ways, were trying to do within the constraints of mandatory reporting.

Chapter Six

Conclusions and Recommendations

"Do not go where the path may lead, go instead
where there is no path and leave a trail."

Ralph Waldo Emerson

Introduction

In this final chapter, the key findings and contributions of the study will be outlined, along with its strengths and limitations. This will be followed by consideration of the implications and recommendations for psychotherapy practice, training, policy, and research. The chapter will conclude with a critical assessment of its quality, based on Yardley's (2000) four principles of good-quality qualitative research.

Contributions of the Study

This study is the first of its kind in Ireland to highlight and privilege the lived experiences and voices of psychotherapy clients as they navigate their way through the mandatory reporting of their abuse during psychotherapy. By doing so, it offers an important, unique and original contribution to the field of both psychotherapy and mandatory reporting. By privileging clients' lived experiences, this study addresses a significant gap in the existing literature, which has predominantly focused on the therapists' experiences and perceptions of mandatory reporting during therapy. The voices and experiences of the psychotherapy client have been largely absent in the literature.

Another first for this study is that it is the first to consider how adult survivors, as a homogenous group, experience the reporting of their abuse during therapy, and how this impacts

their experience of therapy, the therapist and the therapeutic relationship. The findings are of immense value, as they provide insight into areas previously unknown or known only through therapists' anecdotal accounts. A further unique aspect of this study, compared to some earlier studies, is the use of the Interpretative Phenomenological Analysis methodological approach. This allows for in-depth, idiographic accounts of the client's experiences, which have uncovered novel contributions to the understanding of reporting during therapy. One such contribution is the idea of a 'high-stakes journey of disclosure' that emerged from the study's findings and offers a useful organising structure to help understand and highlight the experiences of adult survivors as they navigate mandatory reporting in therapy. This framework shows how adult survivors engaged in an active decision-making process regarding their abuse disclosure, based on their need for autonomy. Regardless of the experience or knowledge regarding mandated reporting, when it actually arrived in the therapy, adult survivors' immediate response was shock. Once this was settled, the experience of the reporting process and the meaning associated with it rested on a turning point, where it could be harmful and re-traumatising, or healing and transformative. The fulcrum of this turning point was the therapist and the therapeutic relationship. Finally, an attempt to get back to a sense of autonomy and agency (the starting point of the journey), adult survivors attempt to exercise their agency within the constraints imposed by mandatory reporting.

The findings build on 'self-determination theory', a theory of wellness from the field of psychology (Ryan & Deci, 2017). This theory can serve as a guide for psychotherapy practice when working with retrospective mandated reporting. The journey of 'self-determination', discussed in Chapter Five, that emerged from the findings, provides a functional organising structure for understanding and recognising the particular therapeutic needs of adult survivors

when their disclosed abuse required mandated reporting. The framework illustrates how, by understanding and meeting clients' needs for autonomy, competence, and relatedness, even within the restricted space of mandated reporting, therapists can support clients' psychological growth and well-being (Deci & Ryan, 2000). Adult survivors desire autonomy to decide for themselves how much of their abuse to disclose. The need for clear, open communication very early in the therapeutic relationship around the limits of confidentiality is important and facilitates the client's ability to make choices regarding their abuse (Darby & Weinstock, 2018). Building the client's competency in their abilities around reporting is an important aspect, along with relational connection.

Finally, findings from the study, when situated in the philosophy of trauma-informed care can also offer psychotherapy practice, an understanding of the trauma needs of the adults survivors and how being trauma-informed can help create an environment for the clients where they can feel safe to open up and share their experiences, where the signs of trauma are recognised and address and re-traumatisation is avoid or minimised (Fisher, 2021). Considering the retrospective mandate reporting within the framework of these two related theories offers a unique approach for psychotherapy practice. Importantly, these contributions are also relevant to other professions of mandated reporters working with adult survivors of abuse.

In summary, this study offers valuable insights into how adult survivors experience the mandated reporting of their abuse, experiences that have remained largely underrepresented in the existing empirical literature. Furthermore, it contributes to the enrichment of knowledge and understanding of this distinctive yet prevalent aspect of psychotherapy, which both therapists and clients encounter regularly within the therapeutic domain.

Implications and Recommendations

For Psychotherapy Practice and Psychotherapists

This research presents significant implications for the therapeutic practices of psychotherapists, emphasising the crucial role their interactions with mandatory reporting have on their clients' experiences. It underscores the importance of adhering to the Code of Ethics, particularly regarding informed consent and the limitations of confidentiality. By offering clients choices and striving to balance the power dynamics that mandatory reporting can exacerbate, therapists can create a more supportive environment.

To assist therapists with this, both Magee (2021) and Pietrantonio et al. (2013) argue that adopting the 'SPIKES' protocol (created by Baile et al., 2000 for use in cancer care) when reporting childhood abuse can help maintain the therapeutic relationship. Although Magee (2021) suggests using this protocol when dealing with parents of abused children when discussing the reporting process, it may also apply to adult survivors of abuse when their abuse is being reported. This protocol involves six chronological steps: (1) setting – this concerns considering the conversation and setting of the conversation before it takes place, checking with peers, supervisors and Tusla to establish if reporting is required before talking to the client; (2) perception – this involves establishing the knowledge and perceptions of the person about what they know, for example, about mandated reporting. This step recognises how high levels of stress and anxiety can impact a person's cognitive function and ability to understand and/or retain information presented to them (Ghaffar et al., 2012). The therapist taking time and demonstrating patience and a willingness to ensure the client has understood what was said can help lessen confusion. A slower pace and the use of opened-ended questions can be used to evaluating the client's understanding, offers an opportunity to address any potential

misconceptions before they cause further distress (Baile et al., 2000); (3) invitation – focuses on asking the client questions about how they would like the process to be, what level of involvement and information they would like; (4) knowledge – is about sharing information with the client about the reasons for making the report, what they can expect during the reporting process and what might happen next; (5) emotions – paying attention and responding to the clients emotions throughout the conversation is essential. Allowing the time and space for these emotions to be observed and experienced, named and explored. Letting the client know, through empathy and non-judgment, that their emotions, whatever they are, are welcome and accepted is important in maintaining and preserving the therapeutic relationship. The use of emotional regulation techniques (Gross, 2014; Linehan, 2015) can help the client regulate these emotions, ensuring they remain present during the session. Clinicians who acknowledge their own emotions around the reporting process can better support the client's experience, especially when the client's emotions are directed to the clinician. Finally, (6) strategy and summary - which involves offering a clear, concise plan of what happens next and the various support available.

This SPIKES protocol offers therapists a structure when discussing the need to make a mandated report with their clients. It offers the client the opportunity to share their feelings and discuss their own thoughts, knowledge, and expectations about the process they may have considered before therapy.

A further recommendation relates to the critical position psychotherapists occupy when supporting adult survivors who engage in reportable disclosures during therapeutic sessions. It is essential for practitioners to acknowledge their obligation as mandated reporters to notify Tusla of all instances of abuse, thereby prioritising the well-being of their clients, via transparency.

This necessitates a conscious integration of the reporting responsibility into their professional identity as therapists. Although many practitioners may perceive the roles of therapist and mandated reporter as separate, findings from the current study indicate that, from the perspective of the psychotherapy client, no such distinction exists. This intricate interplay between ethical obligations and the necessity for client support is fundamental to establishing trust and facilitating healing within the therapeutic alliance. Furthermore, it is paramount that therapists possess a comprehensive understanding of the reporting procedures and implications involved, as existing research suggests that a lack of clarity regarding these processes can adversely affect client outcomes (Rokop, 2003).

The findings of this study carry substantial ramifications for psychotherapeutic practice. A particularly salient discovery is the potential influence of the therapist on the client's experience during the reporting process, which is notably shaped by the therapist's personal perspectives and experiences regarding such processes. It is imperative that therapists engage in reflective practices, whether through formal training or supervision, to examine these factors critically. This reflective exploration is essential in order to mitigate any inherent biases or blind spots that may inadvertently affect their professional conduct within the therapeutic relationship.

In the context of retrospective reporting, it is essential to recognise that the psychotherapy client is typically an adult survivor of childhood abuse, thereby having experienced significant trauma. This traumatic history can manifest in various ways, necessitating that clinicians possess a comprehensive understanding of trauma-informed care. Such care is anchored in key principles: safety, trustworthiness, transparency, choice, collaboration, empowerment, control, and the establishment of therapeutic relationships (Herman, 2015; Substance Abuse and Mental Health Services Administration, 2014). Notably, these principles bear a resemblance to the Self-

Determination Theory of wellness, previously discussed in Chapter Five (Ryan & Deci, 2000), highlighting a shared focus on the empowerment and autonomy of individuals in their healing processes.

The concluding area for consideration involves the necessity for therapists to recognise that clients may have invested substantial time prior to initiating therapy deliberating the potential disclosure of their childhood abuse, as evidenced by the findings of this study. Therapists should leverage this awareness to foster a therapeutic relationship that encourages open and transparent dialogues regarding mandatory reporting obligations. This approach is consistent with the principles of trauma-informed care and aligns with the tenets of self-determination theory, facilitating a more supportive environment for clients navigating these complex conversations.

For Clinical Supervision and Supervisors

The findings underscore the essential role of clinical supervision in facilitating the effectiveness of psychotherapists who work with adult survivors of childhood abuse, particularly in contexts characterised by mandatory reporting obligations. It is imperative that supervision provides a dedicated space for practitioners to introspect on the relational and emotional implications of mandatory reporting, rather than solely prioritising legal compliance, as discussed above. Supervisors are urged to assist therapists in examining how these reporting obligations may influence therapeutic dynamics, including safety, trust, and client disclosure. Attention must be paid to instances where mandatory reporting disrupts or destabilises the therapeutic alliance. Reflective supervision serves as a crucial mechanism through which

practitioners can recognise and manage their own anxieties, fears of liability, and defensive behaviours that might manifest within the therapeutic relationship.

Furthermore, supervision should foster the development of therapists' confidence and clarity regarding reporting thresholds and procedures. Ambiguity in this area can inadvertently be conveyed to clients, thereby heightening their distress. Supervisors can play a pivotal role in guiding practitioners in engaging in transparent, compassionate dialogues about mandatory reporting with clients, including the need to revisit these discussions as the therapeutic process evolves. Moreover, supervisors should direct attention to the dynamics of power, control, and clients' histories of trauma when making reporting decisions. It is critical to acknowledge that survivors' reactions may be influenced by past violations, rather than mere avoidance or resistance. Ultimately, supervision must validate the emotional labour entailed in supporting clients through the reporting processes and promote an enduring commitment to reflective, attuned practice, particularly at the intersection of legal obligations and therapeutic care.

For Training

The findings from this study suggest that mandatory reporting training for psychotherapists (both in training and accredited clinicians and supervisors) requires more extensive training inputs than are currently available in Ireland. Basic training on mandatory reporting focuses on awareness and identification of potential abuse, and the steps needed to make reports (see HSE's Children First Training). Although this aspect of training is important and forms the foundational knowledge base of mandatory reporting, it does not address the specific needs of adult survivors making a reportable disclosure in therapy. Training programmes need to include a focus on understanding the key aspects of containing and managing a

disclosure during the therapeutic relationship. Such as understanding that abuse disclosure is an active, ongoing decision-making process shaped by fear, risk, and anticipated consequences. Skills to assist clients in managing shock responses and regulating their emotional responses to reporting are important skills for therapists to have when dealing with mandated reporting. To also provide an understanding of the significant impact the therapist can have on the turning point of harm or healing. Training on relational skills such as maintaining trust, acknowledging power asymmetries, avoiding defensiveness, and actively repairing ruptures. Although all of these skills are taught on psychotherapy training courses, it is important that they are taught together specifically for managing a mandated report.

Training also needs to focus on reflective practice to explore therapists' own views, opinions, and experiences of mandatory reporting, along with their views and experiences on power, authority, and ethical tension and how these can impact this turning point with clients. Training should also include being able to recognise and support client agency and autonomy.

Training or psychoeducation for adult survivors is also highlighted in the findings, in the sub-theme *'Needing Guidance'*, the participants were actively looking to their therapists for knowledge and guidance about the mandatory reporting process, so it is important that therapists are equipped with the skills and knowledge to meet this need.

For Policy

The starting point for mandated reporting in Ireland encompassed a broad scope, including the necessity of reporting disclosures of childhood abuse made by adult survivors. This expansive interpretation of the law, particularly regarding retrospective reporting, faced significant legal challenges between 2022 and 2024. During this period, the law swung to an

extreme, mandating the reporting of every retrospective disclosure, which posed serious implications for psychotherapists, therapy services, and adult survivors alike. Now, with the recent court ruling in the appeal case, the legal landscape has settled into a more balanced perspective. The focus of reporting has shifted from solely being focused on the disclosure of childhood abuse to assessing the potential current risk to children posed by an abuser (Mooney & Daly, 2024). The findings from this study strongly support this updated understanding of the law, as all participants expressed their willingness to report their own abuse if it meant protecting children at risk.

However, the findings also suggest that reporting retrospective abuse requires a deeper understanding of trauma, as those disclosing childhood abuse are abuse victims, and the reporting process has been experienced by the participants in this study as 'a high-stakes journey of disclosure'. It is essential that policies regarding mandated retrospective reporting of child abuse integrate a focus on trauma-informed practices to ensure that survivors are supported appropriately while safeguarding children in need. The *'Barnahus'* model, developed in Iceland, may offer some direction on how to achieve this. This model acknowledges that the process of 'telling' about abuse, by children, can be traumatic and re-traumatising; this also applies to adult survivors (McElvaney, 2015; Ullman, 2017). The model's emphasis on safety, sensitivity, and coordinated interagency response highlights the need for therapeutic and legal systems to work together in ways that minimise re-traumatisation and uphold the survivor's sense of control, which aligns with the needs of adult survivors and their disclosures. Therefore, in contexts where mandatory reporting obligations apply to adults, applying *Barnahus*-informed principles could support more ethical, transparent, and empowering responses. For adult survivors, whose experiences of disclosure are often shaped by fear of losing confidentiality or agency, such an

integrated and compassionate approach could help reconcile the tension between legal duty and therapeutic trust. Consequently, *Barnahus* offers a valuable conceptual lens for considering how survivor-centred practice might evolve within mandatory reporting frameworks.

A further point worth considering is the growing movement in the U.S, from advocacy groups and reformers pushing for a shift from traditional mandated reporting of child abuse toward a concept described as "mandated supporting" (JMACforFamilies, n.d). These proposals focus on supporting families and children in need of help, rather than automatically referring them to surveillance and punitive investigation (Mosher, 2011; Roberts, 2002). Although still in its infancy and may never gain any widespread support, it does offer an alternative to the traditional model of mandated reporting.

For Further Research

This study is groundbreaking as it represents the first exploration of the lived experiences of adult survivors of childhood abuse who encounter mandatory reporting within the therapeutic context, specifically in an Irish setting. As there are only a handful of previous studies which have explored this issue, there is an urgent need for similar qualitative research to enhance our understanding of the unique needs of these clients when navigating the complexities of mandatory reporting in therapeutic relationships. Subsequent studies should aim to amplify the voices of adult survivors from diverse jurisdictions and increase participant numbers to enrich our comprehension and expand the empirical knowledge base. Additionally, further qualitative investigations involving therapists are essential to examine their experiences of managing the reporting process during therapy. Key areas for exploration include communicating confidentiality limits and providing informed consent in therapeutic settings. Until more is

known about the phenomenon of mandatory reporting in therapy from the client perspective, and a body of research has been built up with new studies, it is difficult to give any further direction for further research.

Strengths and Weaknesses of the Study

One of the key strengths of this study is that it achieved the aim and objectives set out in the introduction: to explore how adult survivors of childhood abuse experience the mandatory reporting of abuse during psychotherapy and how mandated reporting might impact on the clients' experience of the therapeutic relationship, process and outcomes, along with their experience of the psychotherapist. And finally, how clients make sense of the experience of mandatory reporting in their broader life contexts. Another key strength of this study lies in its idiographic and phenomenological focus**,** which allowed for an in-depth exploration of how individuals experienced disclosure and mandatory reporting. Using IPA enabled close attention to participants' meaning-making, capturing the emotional, relational, and temporal complexity of disclosure as it unfolded in their high-stakes journey of disclosure - from decision-making through shock, relational turning points, and constrained agency. This approach was particularly well-suited to a topic (mandated reporting) that is often discussed in legal or procedural terms, but less frequently explored from the survivor's lived perspective.

The study's focus on a vulnerable, sensitive and under-researched population can be considered a strength. Mandatory reporting of historical childhood abuse is a clinically sensitive area, and participants' accounts offer valuable insight into how such policies were experienced by those most affected. By foregrounding clients' voices, the study contributes knowledge with clear implications for therapeutic practice and other mandated professions. The extensive

recruitment strategy employed in the study could also be considered a strength, as it was expansive and inclusive, in order to open up participation to all Irish adult survivors who experienced mandated reporting during therapy. The diversity and richness of the data constituted a significant strength of the study, providing nuanced and comprehensive insights into the experiences associated with mandatory reporting. Finally, the researcher's professional background and experience working in a trauma-informed way with adult survivors of abuse proved useful in accessing the rich accounts of the lived experience of mandated reporting shared in the interviews.

Despite these strengths, several limitations should be acknowledged. As with all IPA studies, the findings are based on a small, purposively selected sample, which limits the extent to which conclusions can be generalised to all survivors of childhood abuse or all therapeutic contexts. The aim of the study was depth rather than breadth, and the findings should therefore be understood as offering experiential insight rather than as a representative sample. The study also relies on retrospective accounts**,** meaning participants were reflecting on experiences that may have occurred some time earlier (see Appendix L for the length between reporting and research interview). While these accounts provide rich insight into meaning-making, they may be influenced by memory reconstruction or subsequent reflection. However, within IPA, such reconstruction is considered part of the phenomenon itself, as the study seeks to understand how experiences are remembered and understood, rather than to establish objective timelines (Smith et al., 2022).

Additionally, participants' experiences were explored from the client perspective only**.** While this aligns with the study's aims, it means that therapists' intentions, decision-making

processes, and organisational constraints were not directly examined but were inferred from participants' perceptions. Finally, the focus of this study was to explore clients' experiences of mandatory reporting in Ireland, under Irish law, the findings may not be transferable to psychotherapy clients' experiences in jurisdictions with different reporting laws and requirements.

Quality of the Study

This section evaluates the study's quality based on Yardley's (2000) four principles for assessing qualitative research: sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance. As endorsed by Smith et al. (2022), these principles are essential for evaluating IPA studies and will guide this assessment. To strengthen confidence in the study's validity and overall quality, examples will be provided to illustrate how each of Yardley's principles was addressed.

Sensitivity to Context

The first principle, sensitivity to context, involves the researcher being aware of the social, cultural, and theoretical context of their research, as well as participant perspectives, ethical issues, and power dynamics (Yardley, 2000). In this study, sensitivity was demonstrated through a thorough literature review, a trauma-informed recruitment and data collection approach, and safeguards such as check-ins, breaks, and debriefing support for vulnerable participants. Participants could withdraw their consent at any time and choose their own pseudonyms to respect their personal experiences. A research video was provided to help participants feel more comfortable before the interviews. All participants received debriefing sheets with support

resources and details of debrief counselling sessions, which highlighted sensitivity to their potential emotional needs following the interview. In the data analysis, participant voices were prioritised, with verbatim excerpts included to illuminate their lived experiences. All of the above elements were thoughtfully integrated into the study's design to ensure sensitivity to the specific context and deeply attuned to participants' experiences. This careful consideration not only enhances the validity of the findings but also fosters an atmosphere of respect and understanding, ultimately enriching the overall research process.

Commitment and Rigour

The second principle concerns commitment and rigour and relates to the researchers' in-depth engagement with the topic, methodological competence/skill, thorough data collection, and depth/breadth of analysis (Yardley, 2000). The researcher's commitment to the current study is demonstrated by the extensive recruitment strategy, particularly the two-pronged approach of direct and indirect recruitment, which ensured that all potential participants had the opportunity to participate. The researcher's willingness to step out of her comfort zone to create and post the recruitment video also demonstrates her commitment to the study. Commitment and rigour were also demonstrated in the time and effort invested in data collection and analysis, especially in honouring the idiographic approach by giving each participant's lived experience equal weight, effort and attention. Also, in the application of the methodology approach, the IPA methodology was consistently followed and applied, as clearly documented and demonstrated in the Appendices O and Q, showing the unique and individual steps of the analysis.

Transparency and Coherence

The third principle focuses on transparency and coherence in the research process. It emphasises that the research process should be clearly explained, with a logical flow from research questions to methodology to conclusions. The research should make sense both internally and in terms of its chosen theoretical framework (Yardley, 2000). Transparency is demonstrated by the clearly presented methods used to collect and analyse the data (See data analysis section in Chapter Three). The data analysis extracts presented in Appendix M-P offer a transparent and clear approach, showing the original transcript, how the initial noting of the descriptive, linguistic, and conceptual comments linked to the transcript, and how these lead to the development of the experiential statements. Demonstrating a clear audit trail was maintained during the analysis stage, a consistent coding system (see Appendix N) ensured that each GET, PET, or ES could be traced back to the original transcript. Transparency was further demonstrated by the keeping of a reflective journal, supervision notes and records, and peer group reflections throughout the research process, which detailed the rationale for decision-making and documented the various challenges encountered.

Yardley (2000, p.222) describes coherence as the "fit" between the research question and the philosophical approach adopted and the method and analysis used. The researcher was very conscious of this coherence throughout the research process to ensure the quality of the findings. The research question clearly set out to explore adult survivors of childhood abuse experiences of mandatory reporting during psychotherapy, a phenomenon widely ignored in the literature. An IPA approach was well aligned with this research aim, as it privileged the lived experience of individual meaning-making within a specific phenomenon in which they are embedded and also allowed for deeper meaning-making by both participants and the researcher. The overall thesis

demonstrated coherence between the philosophical approach of this methodology and the research aim, as shown through the research process and the findings and discussion chapters.

Impact and Importance

The final principle concerns impact and importance. Yardley (2000) asserts that good qualitative research should resonate with the reader, offer insight, and be practically or theoretically relevant. It should contribute meaningfully to understanding the socio-cultural and practical aspects of a topic. This has been demonstrated in Chapters Five and Six of this study, where the current findings and their contribution to understanding experiences of mandatory reporting during psychotherapy are discussed.

Conclusion

In conclusion, this study offers an in-depth exploration of how adult survivors of childhood abuse experience mandatory reporting during psychotherapy. By foregrounding survivors' lived experiences, the findings illuminate disclosure as a complex, high-stakes process shaped by decision-making, shock, relational dynamics, and constrained agency. The study highlights the pivotal role of the therapeutic relationship in determining whether mandated processes are experienced as re-traumatising or transformative and demonstrates that agency can persist in adapted forms even under significant constraint. Interpreted through the lenses of Self-Determination theory and trauma-informed care, these findings underscore the need for therapeutic practices that prioritise transparency, relational safety, and shared power, even within the constraints of mandatory reporting. The findings from this study suggest that these may not be mutually exclusive possibilities.

Attending to these dimensions may not only protect survivors from further harm but also create conditions in which they feel safer to speak, engage, and participate meaningfully in both therapeutic and statutory processes, which will ultimately protect further children from being abused. It may also go a long way to addressing Grace's call to action, "*we have to stop making the victims of abuse responsible for preventing further abuse. It's not our job; we were abused".*

Perhaps the recent reinterpretation of Irish laws, with the transition from a focus on indiscriminate retrospective reporting to one centred on current risk assessment, represents a significant advancement in this call to action and conveys a powerful message to adult survivors: their experiences are validated and acknowledged. This advancement now necessitates a corresponding evolution in other mandated reporting processes, including psychotherapy practices. It is hoped that the findings from this study will go some way to opening that door.

Researcher's Reflective Comments:

As I come to the end of this research project and reflect, I realise it has been a journey of exploration as a researcher, a psychologist, and a human being. It began with a simple question that I didn't have the answer to, and when I searched, I couldn't find an answer either – what is it like to sit in the client's chair when mandatory reporting comes into therapy?. The motivation for this question was to equip myself with knowledge and understanding of the client's experience so that I could find ways to make it easier for them. This was based on the belief that mandated reporting was something separate and external to the therapeutic process, imposed from the outside (society, law), and could be harmful for the therapist, the client, and the therapeutic relationship.

I now see things differently, shaped by the stories, emotions, and tensions encountered along the way. The process has revealed not only what survivors experience, but also how those experiences illuminate the fragile, often conflicted relationship between safety, trust, and care with the duty to report in therapeutic practice. At the outset, the topic appeared to be about policy and procedure — about understanding how mandatory reporting obligations intersect with therapeutic work and how they impacted it. Yet as the research unfolded, it became increasingly clear that these clinical and legal frameworks are not abstract systems; they are lived, embodied realities that profoundly affect people who have already known violation, powerlessness and loss of control. Listening to participants' stories made visible the weight of this tension: the desire for safety alongside the fear of being silenced, the hope for understanding and change alongside the pain of exposure.

Engaging with these narratives was both intellectually challenging and emotionally humbling. It required me to confront my own assumptions about protection, responsibility, and

power. The more deeply I listened, the more I understood that mandatory reporting is not a singular event but a deeply relational experience — one that reverberates within the therapeutic alliance and can either deepen or rupture trust. One that needs respect in the form of trauma-informed care and an acceptance of the client's journey of self-determination.

The process of conducting this study was, for the most part, extremely difficult. Not because of the research process or the participants' stories, but because of the impact of external pressures (life, work, family pressures, and too many illnesses and bereavements), which changed significantly midway through this doctoral journey. There have been many times when I have struggled to continue with the project. Hearing from those around me that maybe I should take a break or give it up because I didn't have the time or focus necessary. Deep down, I knew that if I stepped away, even for a while, I would not return, so I hung on, sometimes by my fingernails, because finding the answer to my original question was important to me. After conducting the interviews, it became even more important, as there was an added responsibility to honour the participants and their experiences. Now, as I end, the importance has increased again, as it's now about communicating the findings of this study so that other psychotherapists and their clients can benefit from the insights shared by the participants.

As this study ends, I have found the answers I went looking for and much more besides. I leave with a much clearer, more nuanced awareness of the paradoxes inherent in the practice of mandated reporting in psychotherapy and of how fundamentally it is a 'high-stakes journey of disclosure' towards self-determination for psychotherapy clients, which is, at its core, relational. I hold hope that as we learn more about the clients' experiences, practice and policy may evolve to better honour the experiences of those most affected - the adult survivors of childhood abuse.

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Appendices

Appendix A: Ethical Approval

Ollscoil Chathair Bhaile Átha Cliath
Dublin City University

DCU

Dr. Aisling McMahon
School of Nursing, Psychotherapy and Community Health

Dr. Melissa Corbally
School of Nursing, Psychotherapy and Community Health

Sharon Cunningham
School of Nursing, Psychotherapy and Community Health

13th August 2021

REC Reference: **DCUREC/2021/161**

Proposal Title: **Sitting in the Client's Chair – An Interpretative Phenomenological Analysis exploring how the mandatory reporting of childhood abuse during therapy influences the client's experience of psychotherapy.**

Applicant(s): **Dr. Aisling McMahon, Dr. Melissa Corbally, Sharon Cunningham**

Dear Colleagues,

Thank you for your application to DCU Research Ethics Committee (REC). Further to full committee review, DCU REC are pleased to issue approval for this research proposal.

DCU REC's consideration of all ethics applications are dependent upon the information supplied by the researcher. This information is expected to be truthful and accurate. Researchers are responsible for ensuring that their research is carried out in accordance with the information provided in their ethics application.

Materials used to recruit participants should note that ethical approval for this project has been obtained from the Dublin City University Research Ethics Committee. As part of DCU REC's ongoing monitoring process, during your research you may be asked to provide DCU REC with a progress report. Should substantial modifications to the research protocol be required at a later stage, a further amendment submission should be made to the REC.

Yours sincerely,

Dr. Melrona Kirrane

DCU
Research & Innovation

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Dr. Melrona Kirrane
Vice-Chairperson
DCU Research Ethics Committee

Appendix B: Letter for De-briefing Counselling

3rd February 2021

To whom it may concern,

The Healthy Living Centre will provide one debriefing session, provided by a member of the Psychotherapy team for participants taking part in research undertaken by Sharon Cunningham.

Catherine Timmins

Catherine Timmins

HLC Coordinator

Appendix C – Recruitment Flyer

We want to learn more about how the mandatory reporting of childhood abuse influences the client's experience of psychotherapy.

We're hoping you can help.

Researchers at Dublin City University want to learn about the experiences of adults who disclose childhood abuse during psychotherapy, and this results in a mandatory report of child abuse being made. We are interested to learn more about how the reporting process influences the client's experience of psychotherapy. This research study is for people over 18 years of age.

Research is always voluntary.

Would the study be a good fit for me?

This study might be a good fit for you if:

- You have attended counselling or psychotherapy.
- You have experienced childhood abuse and disclosed your abuse in counselling or psychotherapy.
- This disclosure resulted in a mandatory report of child abuse being made to the Child and Family Agency – Tusla.

What would happen if I took part in the study?

If you decide to take part in the research study, you would:

- Attend a research interview, either face-to-face or online.
- The interview will last about 1 - 1½ hours.
- Talk about how the mandatory reporting of your childhood abuse during therapy influenced your experience of psychotherapy.
- You will not be asked to talk about your childhood abuse.



There may be some indirect benefits from taking part in the study.

- The opportunity to express and have heard your experience of mandatory reporting of childhood abuse during psychotherapy.
- Sharing your experiences to inform future psychotherapy practices.

To find out more about the research study or to take part, contact Sharon Cunningham – Researcher on

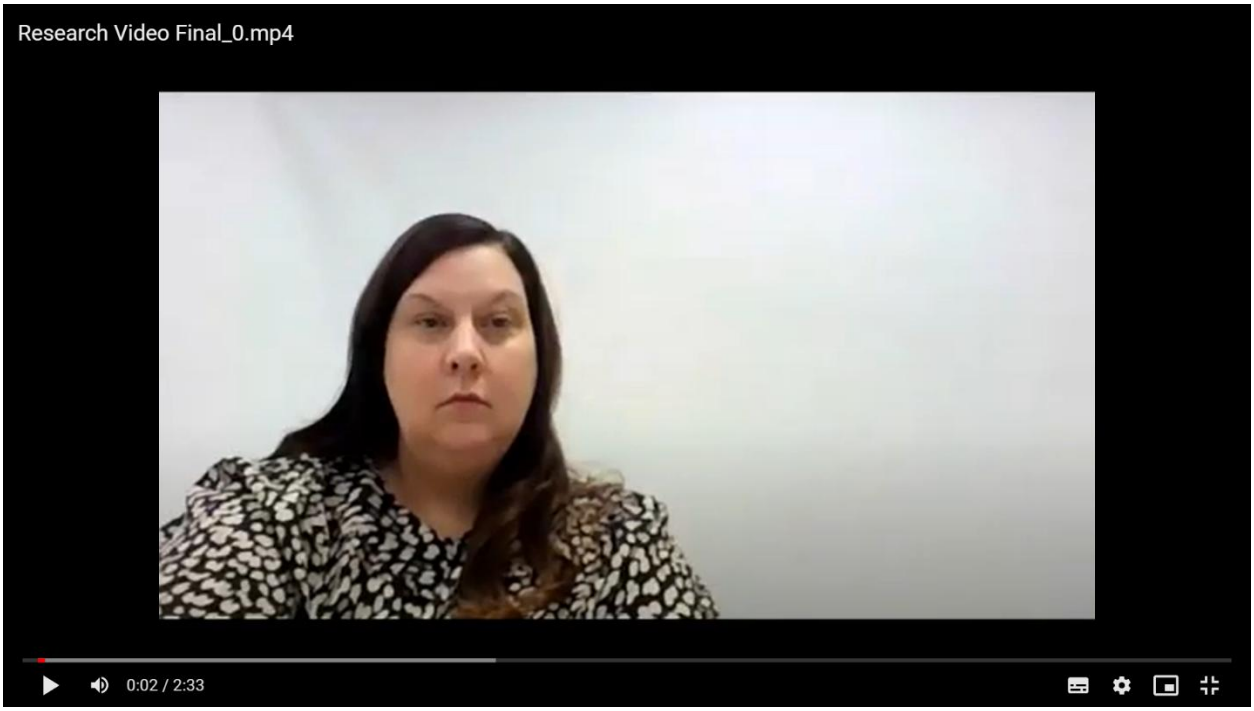
- Phone: 086 445 1186
- Email: sharon.cunningham35@mail.dcu.ie
- https://sites.google.com/mail.dcu.ie/mandatoryreportingresearch.home
- Or just scan QR code opposite

Appendix D – Recruitment Website



https://sites.google.com/mail.dcu.ie/psychotherapy-and-mr-research-/home

Appendix E – Recruitment Video



https://sites.google.com/mail.dcu.ie/psychotherapy-and-mr-research-/video

Appendix F – Information Sheet

Research Study Information Sheet

Introduction to the study

The title of this research study is;

> Sitting in the Client's Chair – Exploring how mandatory reporting of childhood abuse during therapy influences the client's experience of psychotherapy.

Sharon Cunningham, a student on the Doctorate in Psychotherapy programme, is conducting the study under the supervision of Dr Aisling McMahon and Dr Denise Proudfoot, both at DCU School of Nursing, Psychotherapy and Community Health.

Contact Details:

- Sharon Cunningham – 086 455 1186 & sharon.cunningham35@mail.dcu.ie
- Dr. Aisling McMahon – aisling.macmahon@dcu.ie
- Dr. Denise Proudfoot – denise.proudfoot@dcu.ie

Purpose and Rationale of the study

This study aims to uncover how the mandatory reporting of childhood abuse during therapy influences the client's experience of psychotherapy.

Previous research suggests that mandatory reporting can positively and negatively impact the therapy, therapeutic relationship, and outcome of therapy. However, most of these previous studies have focused on the perspectives of the therapists. This study explores the experience from the psychotherapy client's perspective, giving the client's experience a voice.

What does participation involve?

You are invited to take part in a research interview where you will have the opportunity to discuss your experience of mandatory reporting of child abuse during psychotherapy.

The interview will last about an hour to an hour and a half, followed by a short debriefing. The interview will occur either face-to-face at a mutually convenient location or virtually via Zoom or a telephone call. The interview will be audio or video recorded.

You are asked not to name any third parties during the research process.

Before the interview, you will be asked to read and sign a consent form confirming your willingness to partake in the study.

What are the potential benefits and risks in taking part in the study?

No direct benefits are anticipated; however, participation in the study will allow you to reflect on your experience of mandatory reporting of child abuse during psychotherapy. Also, sharing your experiences may inform future psychotherapy practice and give psychotherapists more understanding of the client's experience.

Although you will not be asked directly about your childhood abuse experiences, there is a potential risk that you may become distressed during the interview when discussing your experiences of the mandatory reporting of your abuse and how this impacted your experience of psychotherapy. In this event, the interview can be paused, stopped, and you can withdraw from the study before the study's data analysis

stage, which will be three weeks from the interview. There will also be an opportunity to discuss your experience of the interview with the researcher at the end of the interview. If you need further support, the researcher will direct and assist you in accessing the relevant support.

How is my privacy protected?

Research data and materials will only be accessible to those working on the research team. All personal details and identifying information will be removed to protect your privacy. The transcripts will be anonymised and securely stored. While every effort will be made to protect your anonymity, due to the small number of participants and direct quotations from the interviews used in the write-up of the study's findings, anonymity cannot be 100% guaranteed.

Are there any legal limits to data confidentiality?

The study material will be subject to legal limitations, meaning that it could be subject to subpoena, freedom of information claim or mandatory reporting of child abuse and neglect disclosed during the research interview that was not previously disclosed and reported. Confidentiality cannot be maintained in the event of disclosure of information that involves a risk to you, another person or a child or a vulnerable adult. If any of these issues should arise, the researcher and research supervisors will discuss the management with you.

How will the data be used and disposed of?

Data will be collected in two stages. The first will be when you make contact with the researcher and express an interest to be involved in the project. Data collected at this stage will be your contact details and personal details, ensuring that you meet the inclusion criteria of the study. The second stage of data collection is during the researcher interview. The data collected via the research interviews will be audio or video recorded. Once transcribed, the audio and video recordings will be permanently deleted. The researcher will analyse the content of the interview to identify pertinent themes.

All the data will be stored on the researcher's restricted access folder on the DCU secure Google Drive. Any hard copy material will be stored in a locked filing cabinet in the researcher's home office.

All personal data (names, addresses, email addresses, phone numbers) will be disposed of at the end of the research project. All other data collected will be held for a period of five years following the completion of the research project. After this period, all data will be disposed of securely.

The research findings will be available in the DCU library. It is hoped that the findings will be presented at a psychotherapy conference and submitted for publication in an international journal publication. All participants have the right to access their own data, which can be done by contacting the DCU Data Protection Unit. This study's data controller is Dublin City University, and the Data Protection Officer is Mr Martin Ward (data.protection@dcu.ie / 01 7005118).

Do I have a right to withdraw from the study?

The choice to participate or not in the study is entirely voluntary. You are free to withdraw from the study up to the point of data analysis, and this will be three weeks from the interview.

How will I find out what happens with the study?

You can request a copy of the study's findings during the research interview or at any point after that by emailing sharon.cunningham35@mail.dcu.ie.

If you have any queries regarding the study:

You can contact any research team member at the numbers and emails above if you have any questions or queries about the study.

Furthermore, it is important to note that if you have any concerns about this study and wish to contact an independent person, please contact: The Secretary, Dublin City University Research Ethics Committee, c/o Research and Innovation Support, Dublin City University, Dublin 9. Tel 01-700 8000, Email rec@dcu.ie.

Appendix G – Informed Consent Form – Paper

Informed Consent Form

Title of the Study: "Sitting in the Client's Chair – An Interpretative Phenomenological Analysis exploring how mandatory reporting of childhood abuse during therapy influences the client's experience of psychotherapy."

Researcher: Sharon Cunningham (Sharon.cunningham35@mail.dcu.ie), School of Nursing, Psychotherapy and Community Health

Supervisors: Dr Aisling Mc Mahon (aisling.mcmahon@dcu.ie) & Dr Denise Proudfoot (denise.proudfoot@dcu.ie DCU School of Nursing, Psychotherapy and Community Health.

Ethics Committee DCU Research Ethics Committee (rec@dcu.ie)

Purpose of the Study: The purpose of this research is to explore how the mandatory reporting of childhood abuse influences the client's experience of psychotherapy.

If you agree to participate in the study, you will be invited to take part in an interview with the researcher. During the interview, which will last between 60-90 minutes, you will be asked to share your experiences of mandatory reporting and how it influenced your experience of psychotherapy. The researcher may also ask you questions about your experience. You are asked not to name any third parties during the research process.

If you consent to take part in the study, please complete the following:

I have read the Participant Information Sheet (or had it read to me)	Yes	☐	No	☐
I understand the information provided	Yes	☐	No	☐
I understand the information provided to me about data protection	Yes	☐	No	☐
I have had an opportunity to ask questions and discuss this study	Yes	☐	No	☐
I have received satisfactory answers to all my questions	Yes	☐	No	☐
I am aware that my interview will be audio or video recorded	Yes	☐	No	☐

I am aware that it is my choice to participate in the study and that this participation is voluntary. I understand that I am free to withdraw from the study for any reason at any point before the data from my interview is analysed. This will be three weeks from the date of the interview.

I understand that my data will be kept secure at all times, and my name will not be divulged to anyone within the limits of confidentiality noted in the study's Plain Language Statement.

My name will be anonymised to protect my identity. However, given the small number of participants and the fact that direct quotes will be used in the study findings. I am aware that anonymity cannot be fully guaranteed. I also understand that the findings from this study (including my quotes) may be used in the publication of a peer-reviewed journal article and will be in the online publication of the doctoral thesis.

Furthermore, this study is subjected to legal limitations, which have been explained to me. I am aware that my personal data (name, address, phone no. email address) will be destroyed at the end of the research project. All other research information gathered during the research will be securely deleted and/or shredded five years after the completion of this Doctorate study.

I have read and understood the information in this form. The researcher has answered my questions and concerns, and I have a copy of this consent form. Therefore, I consent to take part in this research project.

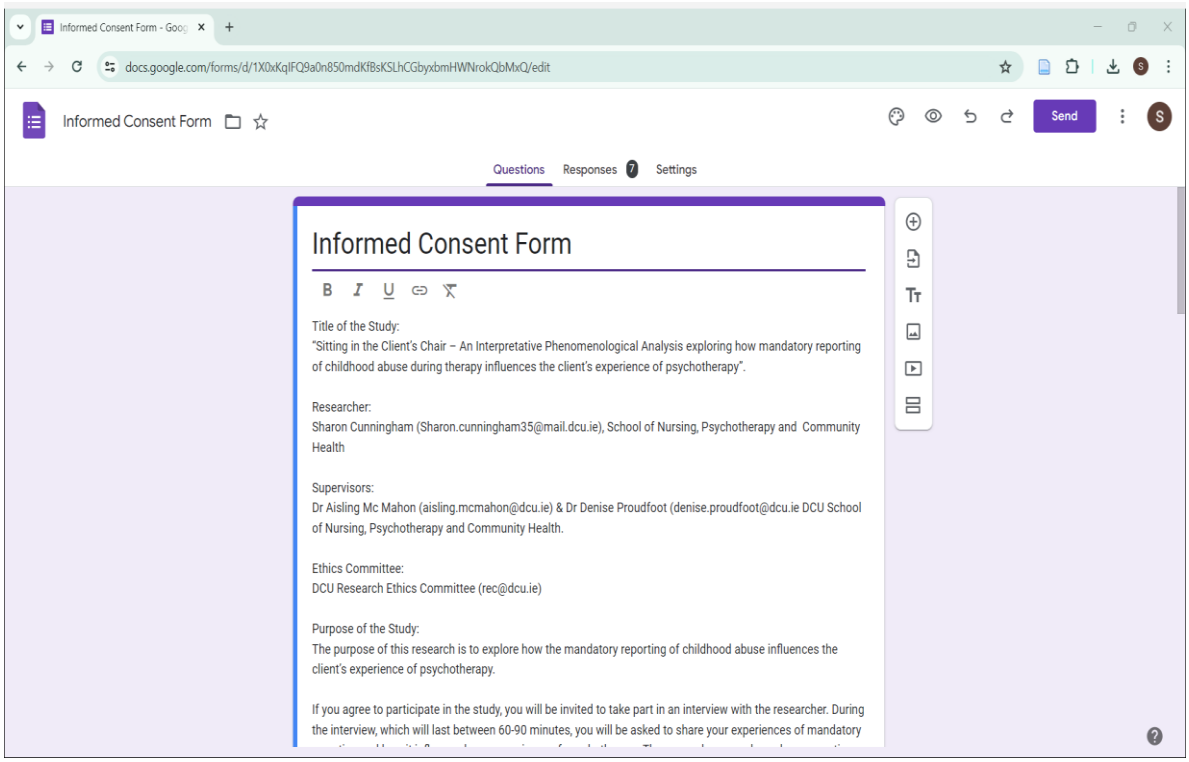
Participants Signature: _____

Name in Block Capitals: _____

Witness: _____

Date: _____

Appendix H – Informed Consent Form - Electronic



https://docs.google.com/forms/d/1X0xKqIFQ9a0n850mdKfBsKSLhCGbyxbmHWNrokQbMxQ/edit

Appendix I – Interview Schedule

Interview Schedule

1) ***Can you tell me about your experience of mandatory reporting during psychotherapy?***

   (Prompt: can you tell me more about how that felt, how did you experience the therapists' response to your disclosure of childhood abuse, can you tell me about how the report was discussed, prepared)

2) ***Can you tell me about how you learnt that your therapist had a duty to report childhood abuse?***

   (Prompt: can you tell me more about that experience? How did you feel at the time? What thoughts did you have? How did knowing about mandatory reporting influence your decision to disclose your own experience of childhood abuse?)

3) ***Can you tell me how you experienced the therapist during the mandatory reporting?***

   (Prompt: Did you change your view of them? if so, how? is there anything that the therapist did or said about mandatory reporting that was helpful or unhelpful for you? Looking back, is there anything you wish your therapist had done differently? If so, what, and why?)

4) ***How do you think the mandatory report affected your relationship with the therapist and the therapy, if at all (the therapeutic relationship- trust, safety, non-judgmental etc.)?***

   (Prompt: how did it change your feeling of safety in the relationship, did it impact your openness with the therapist, was your trust in the relationship affected?)

5) ***How did your experience of mandatory reporting impact your engagement with the therapy, if at all?***

   (Prompt: can you tell me more about that, how did it change your feelings/thoughts about therapy? can you tell me about what impacted the mandatory reporting had on the outcome of your therapy)

6) ***How did your experience of mandatory reporting during therapy affect other aspects of your life, if at all? (e.g., wellbeing, relationships etc.)***

7) ***Finally, is there anything you would like to add about your experience of mandatory reporting that we have not covered?***

Appendix J: Debriefing Sheet

Debriefing Sheet

Title of the study: Sitting in the Client's Chair – An Interpretative Phenomenological Analysis exploring how mandatory reporting of childhood abuse during therapy influences the client's experience of psychotherapy."

Researchers: Sharon Cunningham – DCU -086 455 1186,sharon.cunningham35:mail.dcu.ie

Aisling Mc Mahon – DCU – aisling.mcmahon@dcu.ie

Melissa Corbally – DCU – denise.proudfoot@dcu.ie

Dear ,

On behalf of myself and my research supervisors, I would like to take this opportunity to thank you for your participation today and to acknowledge the valuable contribution you have made to this research project by sharing your experiences with me.

As discussed during our debrief session, sometimes participants can find that feelings of distress can be evoked in the days following the interview.

If, for any reason, the experience of taking part in this research interview does evoke feelings of distress for you, please know that there is support available 24/7. I have listed some support organisations below just in case you need them.

You can also call me for support or check-in regarding any issues raised for you by participating in the research study. My telephone number and email are listed above. Please reach out for help if you need it.

If you have any questions about the study, please contact the research supervisors or me; our contact details can be found above.

Thank you again for your generous participation.

Support Organisations

Connect Counselling:
An anonymous professional telephone counselling service for survivors of physical, emotional, and sexual abuse.
Call: 1800 477 477 ***Website: www.connectcounselling.ie***

One in Four:
Counselling and Psychotherapy for people who have experienced childhood abuse and neglect.
Call: 01 662 4070 ***Website: http://oneinfour.ie***

National Counselling Service:
Free counselling and advocacy service for people who have experienced sexual violence during childhood.
Call: 1800 477 477 ***Website: http://www.hse-ncs.ie***

Rape Crisis Help:
Provides service to any person affected by rape, sexual assault, sexual harassment, or childhood sexual abuse.
Call: 1800 77 8888 – 24-hour ***Website: www.rapecrisishelp.ie***

Samaritans:

Provides emotional support to anyone in distress or struggling to cope.

Call: Freephone 116 123 - 24/7 ***Email: jo@samaritans.ie***

Pieta House:
Telephone and text-based support counselling for people who are suicidal or engaging in self-harm.

Call: Freephone 1800 247 247 – 24/7 ***Website: www.pieta.ie***

Text 50808:
A free 24/7 text service, providing everything from a calming chat to immediate support for people going through a mental health or emotional crisis.

Text HELLO to 50808, anytime day or night. ***Website: www.text50808.ie***

Appendix K: Details of Participant Recruitment

Name	Direct Recruit	Indirect Recruit	How participants heard about the study
Grace		***X***	Received the researcher's email to therapists. Grace is a therapist with personal experience of childhood abuse and mandated reporting.
Sophia	***X***		Saw the advert on Activelink.ie, a public website for research volunteers.
Ben		***X***	Ben's private therapist received an email from the researcher and discussed the study with him.
James		***X***	James's therapist, who was affiliated with one of the specialist organisations, discussed the study with him.
Rebecca	***X***		Saw the advert on Activelink.ie, a public website for research volunteers.
Ivan		***X***	Saw the study on One In Four's social media.
Alma		***X***	Saw the study on One In Four's social media.
Inka		***X***	Saw the study on One In Four's social media.
Anne		***X***	Saw the study on One-In-Four social media.
Helen		***X***	Saw the recruitment flyer in the waiting room of one of the specialist organisations.

Appendix L: Extended Participant's Details and Information

Participant[3]	Gender and age	Type and place of counselling where M.R. was made	History of counselling	Type of childhood abuse	When was the M.R. made	Status of report	Interview Type
Sophia	Female, 40's	One-to-one counselling in a specialist organisation[4]	1st time in therapy	Sexual abuse	18 months prior to interview	Letter received from Tusla – insufficient information to proceed	Zoom, 47 mins
Ben	Male, 70's	One-to-one with a therapist in private practice	26 yrs in and out of therapy due to childhood abuse	Sexual abuse – Perpetrator deceased	2 weeks prior to interview	No follow-up from Tusla at the time of the interview	In-Person, 65 mins
James	Male, 50's	One-to-one counselling in a specialist organisation	1st time in therapy	All four types of abuse	7 months prior to interview	No follow-up from Tusla at the time of the interview	Zoom, 58 mins
Inka	Female, 40's	One-to-one counselling in a specialist organisation	1st time in therapy	Sexual abuse	5 years ago, reported to Gardai after M.R was made.	Tusla is investigating, Gardai investigated, a criminal court case is expected.	In-person, 138 mins

3 Pseudonyms are used to protect participants' anonymity

[4] Specialist organisation refers to state-funded organisations which offer counselling to survivors of abuse. These include Rape Crisis Centres – nationally, One-in-Four, National Counselling Service and Towards Healing

Participant	Gender and Age	Type and place of counselling where M.R made	History of counselling	Type of childhood abuse	When was the M.R. made	Status of report	Interview Type
Rebecca	Female, 30's	One-to-one counselling in a specialist organisation	Attended once previously – unrelated to childhood abuse - abuse not discussed	Sexual and emotional abuse.	3.5 years before interview	Letter received from Tusla – insufficient information to proceed	Zoom, 54 mins
Helen	Female, 60's	One-to-one counselling in a specialist organisation	Yes attended once previously – unrelated to childhood abuse - abuse not discussed	Sexual abuse	2 months prior to interview	Tusla replied that the abuse met the threshold and they would commence an investigation.	Zoom, 55 mins
Anne	Female, 40's	One-to-one with a therapist in private practice and as an in-patient in a psychiatric hospital.	Attended counselling in college – unrelated to the abuse - abuse not disclosed	Sexual abuse	3 reports done 1st 5 years before interview (1 other hospital and one pp)	Letter received from Tusla – insufficient information to proceed	In-person, 80 mins
Grace	Female, 50's	One-to-one counselling in a specialist organisation	Yes, in the USA previously, abuse was discussed but not reported.	Sexual abuse	Prior to M.R. but CF guidelines in place – report made 6 months later	Met with Tusla social worker, deemed there was no risk – did not want to pursue it – no further action	In-person, 58 mins

Participant	Gender and Age	Type and place of counselling where M.R made	History of counselling	Type of childhood abuse	When was the M.R made	Status of report	Interview Type
Alma	Female, 30's	One-to-one with a therapist in private practice	Yes, both as an adolescent and an adult – no disclosure. Therapist asked, but Alma denied any abuse.	Sexual abuse	12 months prior to the interview – Alma also reported to Gardai 6 months after M.R.	Tusla is investigating, Gardai investigated, and as a result a court case is pending.	Zoom, 81 mins
Ivan	Male, 60's	Group therapy during an in-patient stay in a psychiatric hospital	Unknown, in MH services 30 yrs	Sexual & physical abuse - Institutional / Clerical	5 years prior to interview	No follow-up from Tusla. Also reported to Gardai, who investigated and discovered that the alleged perpetrators were deceased.	In-person, 66 mins

Appendix M: Participant's Experience and Knowledge of Mandatory Reporting

Participant	Mandated Person in their Professional Role	Experience in making child protection reports in their professional role	General knowledge and understanding of M.R	No knowledge of M.R. prior to therapy
Grace	Yes	Yes	Yes	-
Ivan	-	-	Yes	-
Sophia	Yes	-	Yes	-
James	Yes	Yes	Yes	-
Inka	-	-	-	Yes
Alma	-	-	Yes	-
Rebecca	Yes	Yes	Yes	-
Anne	-	-	-	Yes
Ben	Yes	-	Yes	-
Helen	Yes	Yes	Yes	-

Appendix N: Extract from Rebecca's Analysis

Rebecca - Initial & Exploratory Notes & Experiential Statements

Experiential Statements	Transcript	Initial Noting & Exploratory Notes Initial noting & thoughts Descriptive Notes Linguistic Notes Conceptual Notes & Things to Consider
Being made aware of reporting requirements from the beginning	*Int:* Right so I think when we ummh we spoke on the phone you said that the mandatory reporting happened in 2019 *Part:* Yeah that's right uh-huh *Int:* You were in (specialist counselling service) *Part:* Yeah yeah so just started in there (clears her throat) sorry *Int:* And how long into therapy did the did the mandatory reporting come up *Part:* Ummh so I started therapy in at the end of June and it was mentioned, I think, pretty much straight away *Int:* Ok	Is Rebecca feeling nervous as the interview starts ? she isn't sure what to expect MR mentioned straight away as therapy commenced Included as part of Informed Consent for therapy ? 'geek go' – straight away, bit of hesitation here, this is the first time she as hesitated

Feeling that she had no choice about reporting Waiting a long time for the therapy door to open and realising that it might be closed by MR Feeling a shared responsibility but no real choice	*Part:* So I I knew from the geck go and then I did the report during our third session *Int:* Ok ok great that gives me a sense right, can you remember ummh how the therapist spoke about mandatory reporting, can you remember when that came up and and what she said or he said *Part:* Yeah so I like I can't remember exactly but when I was there I remember (clears throat) sorry getting the feeling that it was something that had to be done *Int:* Ok *Part:* Ummh cause I remember thinking oh I'll have to not proceed with therapy because at at that point I really didn't want to go through with any kind of reporting and hadn't ever considered it ummh so yeah and I do remember her saying that if I didn't do it if we didn't do the report that it would kind of be hanging over us *Int:* Ok, ok *Part:* I think those were the words she used *Int:* Hanging over you	**'I' and 'our' – she felt like she was doing the report even though it is the therapist is the MP** **She knew about the reporting from the start of therapy and it was done straight away** **Who is the MRpter, she felt she was doing the report – but she isn't MPpter, it is therapist's responsibility to report – Are therapists delegating responsibility ???** **Very hesitant and unsure her – is she anxious remembering this ?** **'getting' how getting ? from the therapist? From herself ?** **Feeling that there was no choice – report had to be made** **Lack of choice, report had to be done – who's lack of choice - not hers but the therapists – she had a choice – how was this taken away – by the therapist ??** **'thinking' – not talking about it, kept to herself** **'have to not' – have too stronger than the not go to therapy ?? no choice – predetermined ??** **Her choice was do the report or leave therapy** **Initial response to reporting -not want to do it, never thought about it** **Hadn't thought about reporting before therapy – therapy forced her to confront this** **'I' and 'we' – she corrected this – did it feel like it was her making the report** **'hanging over us' – inevitable, will need to be done** **See above when she could remember – she now remembers the exact words - was she nervous about sharing ???** **Therapist made reporting feel like a condition of therapy - choice leave therapy or report**

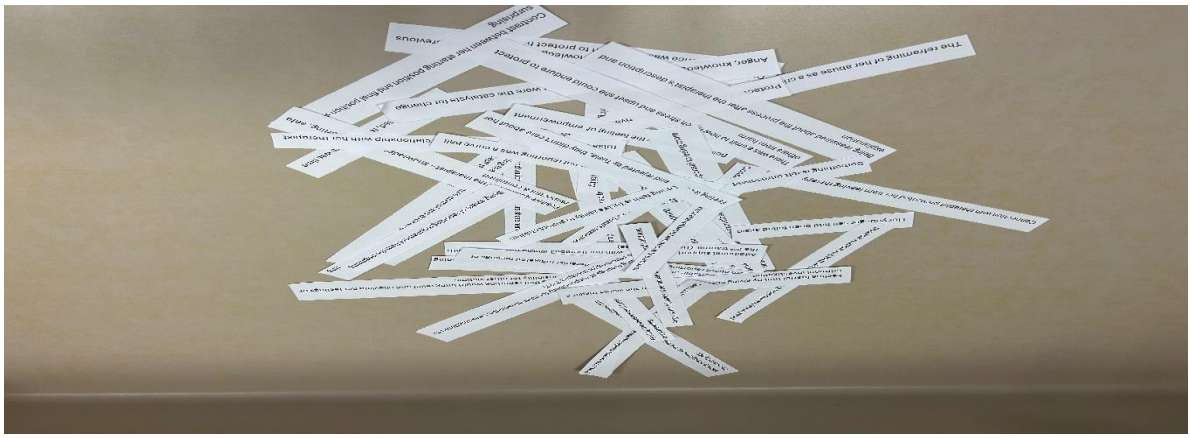
Having intense physical and emotional reactions to reporting	*Part:* Yeah so it did kinda feel like an obligation to proceed with therapy *Int:* Ummh *Part:* I didn't know if I interpreted that right *Int:* But that was how it felt *Part:* Yeah yeah it did for me yeah *Int:* And what was that like having that obligation or feeling that obligation *Part:* It was very stressful and those few weeks were very stressful for me in that I remember feeling quite physically sick and I think it was because of the anxiety around it and ummh yeah and I had waited I think nine months on the waiting list to go to the (specialise counselling service) *Int:* Yeah *Part:* Ummh and yeah and then it was like as soon as I went (laugh) I was told this so I was like ohhhh after all that I can't go through with therapy because I can't do this report *Int:* Ok after all that wait	**Was this condition of organisation ?? one agency has this requirement** **Lack of choice is the therapists not the clients – was therapists responsibility being put on client ?** **'Interpreted that right' - some doubt, but it was ambiguous** **Obligation created a great deal of stress which resulted in physical symptoms** **Decision – stay or report created anxiety, which was heightened because she waited 9m for therapy** **'few weeks' - Stress peaked at the beginning** **'very' 'quite' – response had an impact on her life** **Physical and emotional impact on hearing about MR on the client** **Laugh – highlighting the irony – waited all that time just to not be able to start** **'Told' – something about power here – others knew something she didn't which was important for her to know** **'after all that' – there was a lot in the waiting** **Waiting for therapy and then feeling she cant continue because of MR** **MR block access to help and support via therapy** **Lack of choice and power around MR**

Existing feelings of responsibility for other abuse victims was heightened Going to therapy takes courage and reporting was a curve ball	*Part:* Yeah yeah and it's all I remember you know those few weeks that summer is the thoughts of doing this and the report and what it would mean and then suddenly having well not suddenly but it definitely was it was increased the sense of responsibility ummh for other people who might be victim to the the same person *Int:* Ok and how did that come up how did that responsibility come up *Part:* err I suppose jus just in me it was something I would have thought about quite a lot quite quite frequently and I guess I was quite distressed by it and I don't think I had actually given it too much thought until that point *Int:* umm *Part:* but yeah then feeling a bit you know maybe I I'm responsible for you know *Int:* Yeah *Part:* Yeah *Int:* That must have been really difficult because that's a lot of responsibility on you	**Initial feelings / worry / ruminations about reporting took over her life at the start of therapy** **'suddenly' – correcting herself here why wasn't it sudden, where did it come from – herself or therapist ??** **Worry and concern increased by sense of responsibility for others who might be harmed** **Considering possible current risk makes victims consider possibility of other being harmed – taking responsibility for this** **Hesitant and disjointed speech here – facing something that is difficult ?** **She had thought a lot about the possibility of her abuser harming others which was distressful and caused anxiety** **Contradiction here – previously thought about it quite a lot – to not given it much thought until this point - is the thinking a lot and frequently after she was made aware of it and then it became overwhelming ??** **Considering risk to others is anxiety provoking and distressing** **Anxiety and distressed – emotional impact** **'maybe, I I ' – she isn't sure and hesitant - is this because she doesn't wasn't to accept this ?** **Feeling responsible for others or harm to others ?**

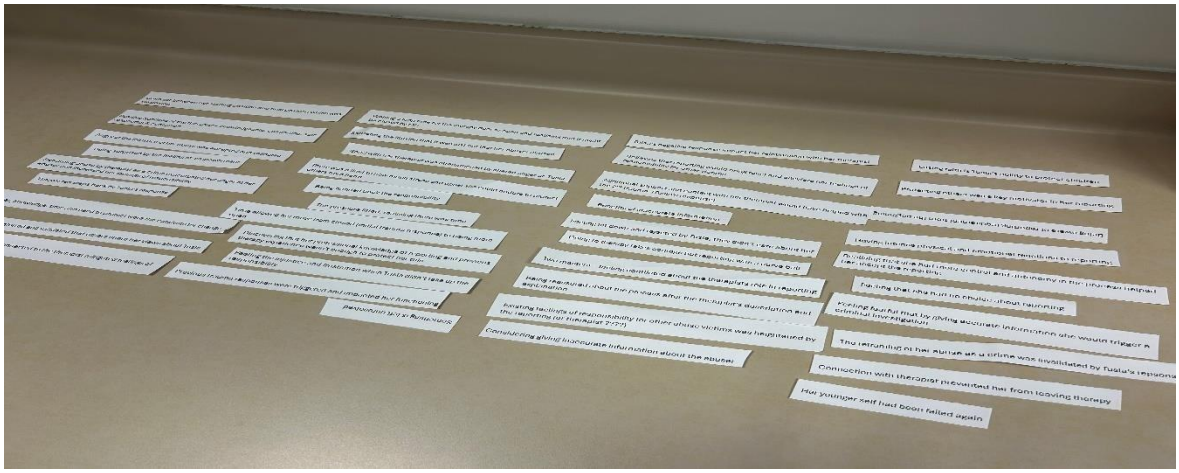
Discovering that her professional knowledge of reporting and previous therapy experience wasn't enough to protect her this time Contrast between her starting position and final position which was surprising and terrifying	*Part:* Yeah and I guess it's it's was difficult anyway to kinda of pulk up the courage to go to therapy and address this and yeah it was like a curve ball kinda being thrown at me *Int:* Umm umm and so my sense is that you didn't have any knowledge about mandatory reporting when you phoned up *Part:* So I did because I would have done Children's First myself ummh but also I been to therapy before and it didn't come up I was told by my previous therapist if I gave a name then they would have to report it ummh *Int:* Ok *Part:* So that was my understanding at the time *Int:* Ummm *Part:* I suppose my understanding was somewhat limited *Int:* Ok ok *Part:* Yeah *Int:* And that first time in therapy where it came in, but the therapist said if you don't if you didn't give a name there was nothing to report do you remember how it felt then	**Deciding to go to therapy and address her abuse was hard and took courage and then to have to face 'others being harmed' wasn't expected.** **'curve ball ' - didn't see it coming, wasn't prepared** **'told' - as above – therapists are telling her – she is passive, also they are the experts/ authority ??** **Had some knowledge of MR but previous experience of reporting in therapy conflicted with this information** **Therapy professions old way to deal with reporting responsibilities before MR law** **Surprised at reporting because prior experience was different** **Entered therapy with belief her abuse wouldn't need to be reported, surprised when told the opposite** I don't think the client heard my question correctly – I asked about the first therapy but her response seems to relate to the current therapy (why dauting and terrified in the first if she didn't need to give name) **Reaction to hearing about need to report – daunting, awful** **Task was daunting and she felt terrified**

Appendix O: Steps to Create Sophia's PETs

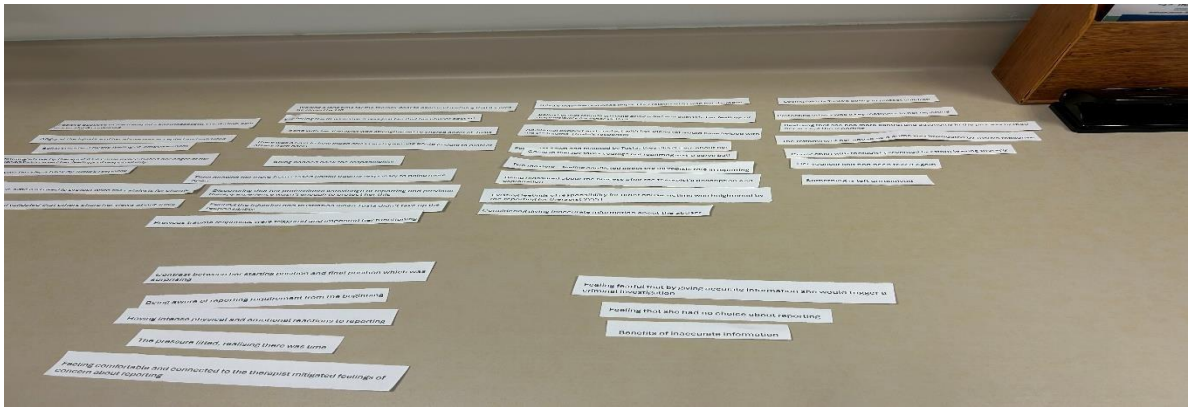
Step 1: Jumbling up the sequence of Experiential Statements



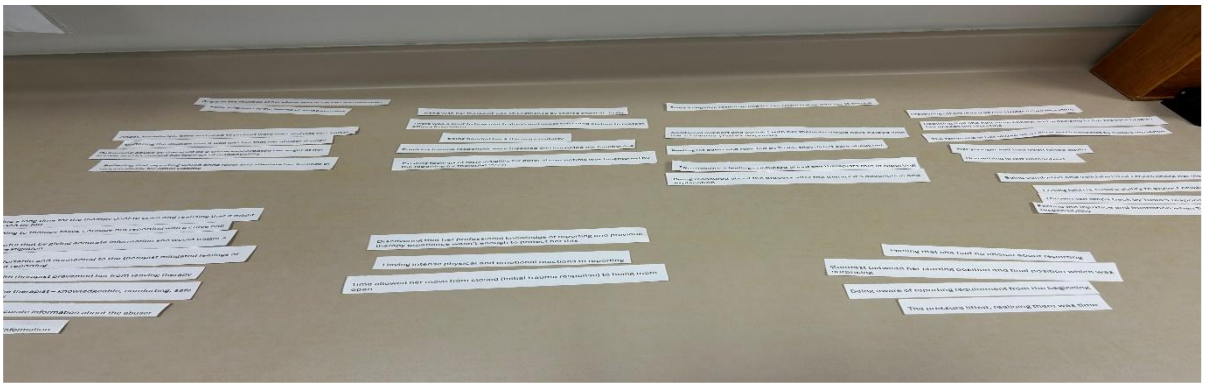
Step 2: Experimental Statements ready for clustering



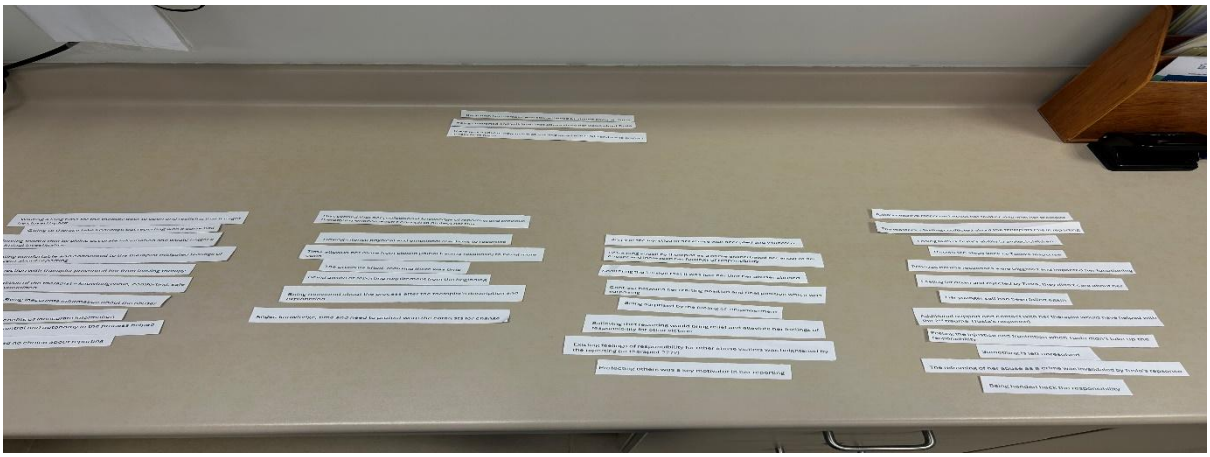
Step 3: Starting the development of the PET's



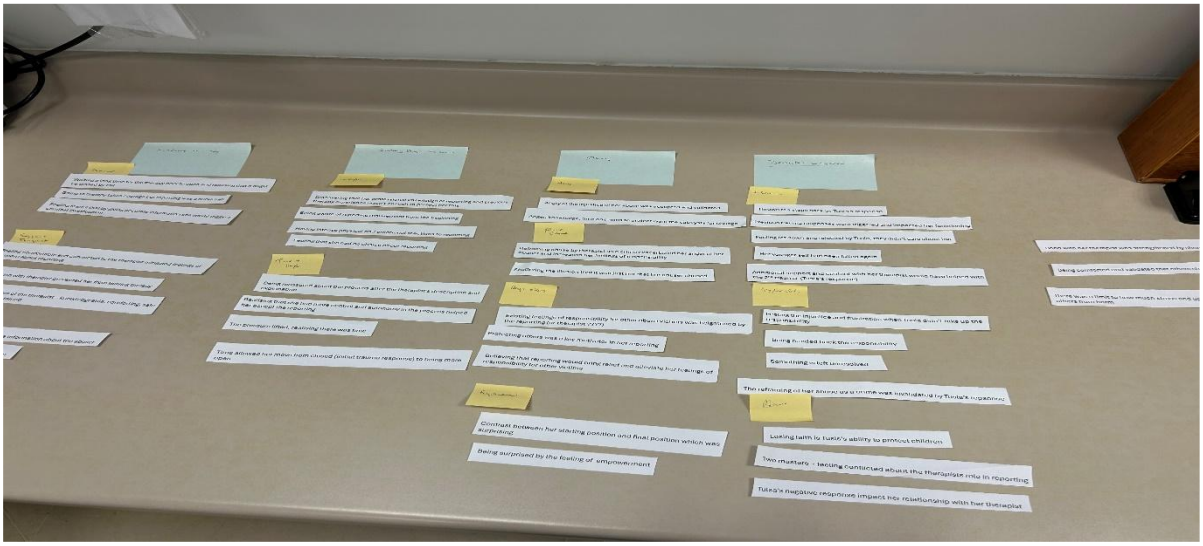
Step 4: Development of PET's continues



Step 5: Four main PET's developed



Step 6: PET's sub-themes developed



Appendix P: Extract from Ben's Table of PETs

Table of Personal Experiential Themes (PETS) for Ben

A. IMPACT OF REPORTING ON THE THERAPY

Initially limited disruption but shock emerged

Being *told* by the therapist that a report needed to be made and being given time to discuss his feelings around this.
"from my therapist .. because, umm, two months ago, she told me about the need to report and our last session, which was just two weeks ago, was on that and umm, very much about the feelings surrounding that and so on. I knew I wasn't happy"

Contrast between initial reaction (e.g. feeling obliged to make the report, rushing to send information) and response after reflecting (e.g. slowing down, wanting to discuss more, connect with therapist). Overall not happy.
"When my therapist mentioned it, and it was in the light of some court case that has been held and where they are required to to do it ummh (pause 5 sec) initially (pause 3 sec) I was rushing to say well look we have to do it you know I'll send you on the information but then I slowed down and that and said no I'll hold on until we've had a talk and further talk about it"

Being able to choose what to focus on in the session, reporting didn't overshadow Ben's immediate needs.
"she mentioned it, but then we went on to what I was dealing with or what had come up for me. It just happened we followed, you know I always think we're a bit like a pair of dogs that are chasing a rabbit somewhere you know".

Ben understood mandated reporting and the limits of confidentiality because of professional/vocational role
"I mean I know as as a priest I know that we are mandated to report if somebody reveals abuse in someone in some context where we can do it, I knew what it was, and I knew we had an obligation to it …. I do spiritual direction so I understand the thing about confidentiality and unless you are harming yourself or potentially harming somebody else".

Abusive experiences are ranked in a hierarchy based on harm/damage, only the extreme ones are on the reporting radar.
"significantly, there is a second experience I had which never is on the same level in the radar because I think it did far less damage the one lets say when I was very young child did".

Immediate response to reporting was overshadowed by other issues, he needed time to recognise the feeling of shock.

"No, not a terribly strong response at that moment I think because there was other stuff that I need to …. but I think it took time for the shock to register … I felt a wee bit there was shock but I was doing the other stuff and we weren't in that immediate thing of…"

Accepting the need to include the victims name when there is a purpose – protect children
"but suppose he were alive I could see the value of mandatory reporting and his name going into the system but I cant see the value of any of the victims that may have had been abused I just cant" (B-24)

Mixed feelings towards the therapist as a mandated reporter

Experiencing the therapist as being part of the reporting process (e.g complicit in doing harm, she was part of the re-victimisation and that reporting against client's wishes puts therapist in position of 'quasi abusers')
"I was aware that some of what I was saying was hard for it it's a woman, for her to hear ummh because I know particularly when I said it was like getting re-victimised, you know in a sense she is caught up in that, you know and that's so unfair and I think (laughed) it is something that should be borne in mind that when a therapist has to report in a way that is unacceptable to the client they too are being caught up in are being made ummmh quasi abusers in a sense do you know".

Believing his therapist would protect him from all avoidable harm (e.g. knowing that the law is forcing her into a position, which is not of her choosing)
"I am quite aware that the reporting is not of her choosing so it's not as if ummh she has chosen to do something that could have been avoided"

Unsure of how Tusla's response to the report will impact the therapeutic relationship/view of his therapist.
"The report has gone in and that ummh it is it's hard to know (pause 20 secs) it's its so hard to know (sigh) I won't really know until maybe … I don't think that it will have any long-term effect but really the proof of that is in the eating of the pudding and (laughs) I'm not sure … then I will be really angry because they will have deprived me of a very good therapist".

Acceptance of the need for reporting is the perpetrator is potentially still a risk
"if it was possible that the person that abused me would could be abusing still then there might be some reason for it being more identifiable although I don't know why the victims name is needed" (B-24)

Precious aspects of therapy are lost

Reporting removes safety and freedom to express, disclose and share experiences of abuse within and outside of therapy.
"well I think its that freedom to rage to, name to, be able to be able to talk even about things like where I have walked past (the facility) … to walk by it and to be able to talk in terms of the name. You wouldn't have had I would have had the freedom to talk about this so that would have

yeah it will be interesting to see now I realise you know I am going to be living with a censor that makes sure nothing else is reportable goes out there"

Therapy is no longer a non-judgemental space, judgement about reporting is inherent in the therapeutic space
"it destroys something oooof ... that sort of non-judgmental thing that you can say anything and you're not thought the worst for it. Now you can say nothing about what has to be reported or it has to be reported so that judgment is already in place"

Dealing with societal/legal changes which directly impact the personal/ intimate process of therapy (this one needs a better quote)
"The court case well when the court case was lost where the recommendation at some meeting she had been at"

B. ITS ALL IN THE NAME – REPORTING IS THE SAME AS ABUSE

Re-traumatising

Reporting involves two aspects for Ben – reporting the individual (the alleged perpetrator, which he was happy to do) and then giving his name as the victim and it going on record (which he experienced as re-traumatising.
"The notion of reporting in its self didn't I don't think it it it it errr annoyed me that much. It's when I came to realise that the reporting involves my name going on record. That I object to hugely and that is a re-victimisation. Well what I experienced was being obliged to go where I don't want to go and to do what I don't want to do. Which is what abuse is about"

Feeling angry that the victim (their name) needs to be reported, they have done no harm
"that all come from the name of the individual .. not when you're the victim"

Name going on record – victim being identified not the perpetrator reflects abuse dynamic – blame the victim
"Just the name, my name going on record only because the victim is identified not the perpetrator" (B-X)

Lack of choice

Sharing information should be Ben's choice and Ben's terms – Believing he should have the right to choice who he shares his information with and the right to protect himself.
"I don't mind, errr, I wouldn't be here if I minded revealing myself to somebody else, but it's on my terms ... even though you're doing research, and you have your terms. It is on my terms, and it is on my terms that I could walk away up to ten minutes ago but you know it is my terms I am choosing it".

Struggling to understand the need for the victims name when the perpetrator is dead

"Whereas when it is historical, the guy is up in an unmarked grave in Glasnevin….) I think they can be balanced by not including the name of the ummh victim once the perpetrator is named and can be checked" (B-25)
"I see no purpose to it when its historic and there is nothing to be gained" (B-24)

Remaining on the record - why

Being uncomfortable with his name remaining on record when there is no risk to children, and feeling he should be able control/choose, based on who he trusts.
"Remaining on record so, it's in one sense its GDPR thing, who gets to see it, who has access to that information, I mean I volunteered my name to you; I chose it if you were to go out and pass that at random you know 'you know what I heard' you know that wouldn't do, but I trust that you won't do that"

Negative views, experiences and perceptions of Tusla impact Ben's feeling of trust about how his information will be handled and panic when he considers their motivation.
"I am not choosing to be put on record in an agency that I distrust hugely. Tusla has not been good to people who have had false reports made about them, and it's a big impersonal juggernaut of a yoke, under-resourced. What is the point of mandated reporting on something where no child is in danger now and the only and it causes a moment of panic there, the only reason I can see that they would have any interest is that they want to check if I'm abusing".

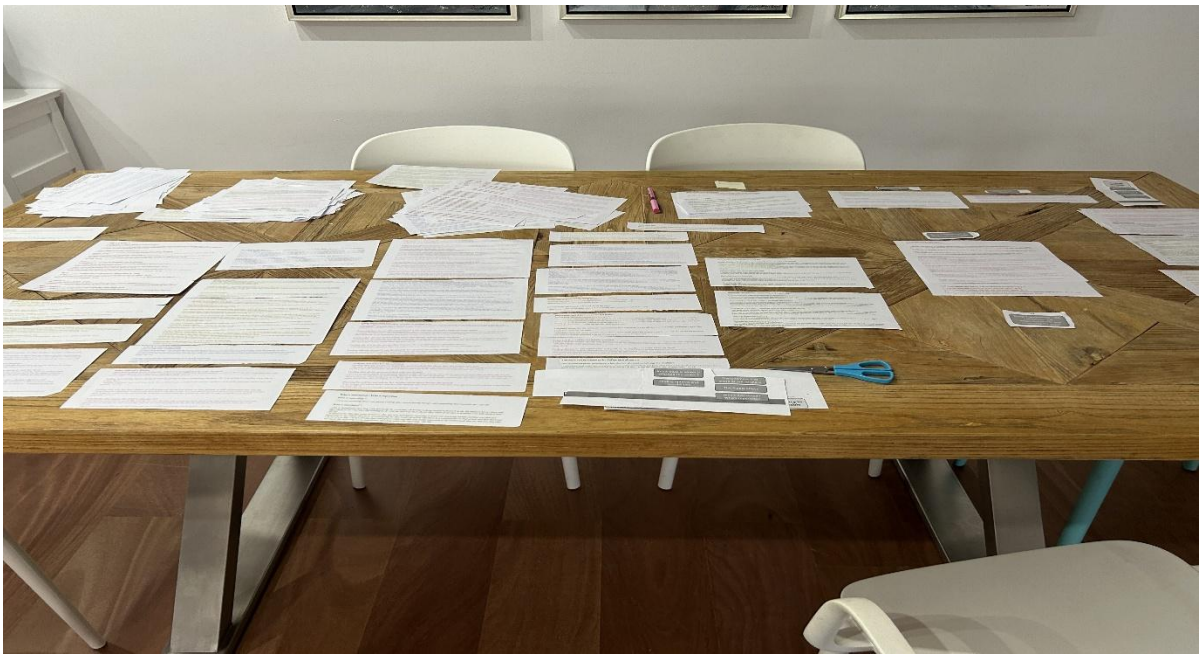
Uncertainty about who will have access to his experience and fearing judgement from Tusla
"Somebody in Tusla, it could be the most compassionate person out or could be sitting oh janny what's what kind of godshite is this" (B-23)

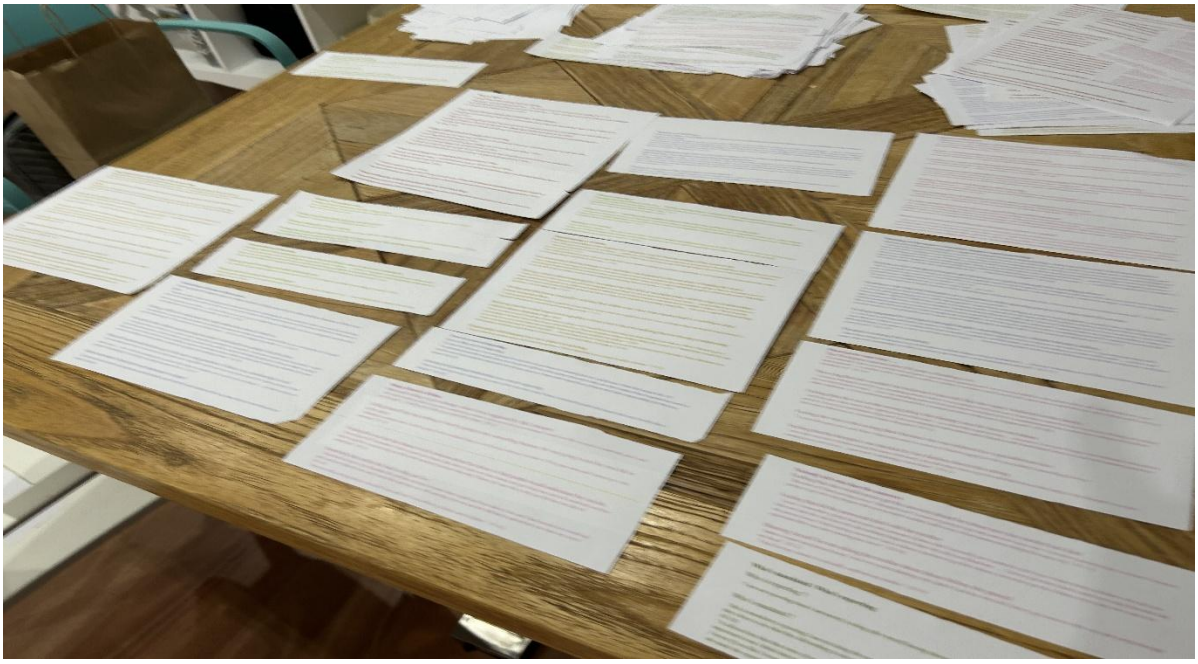
Feeling powerless and complicit

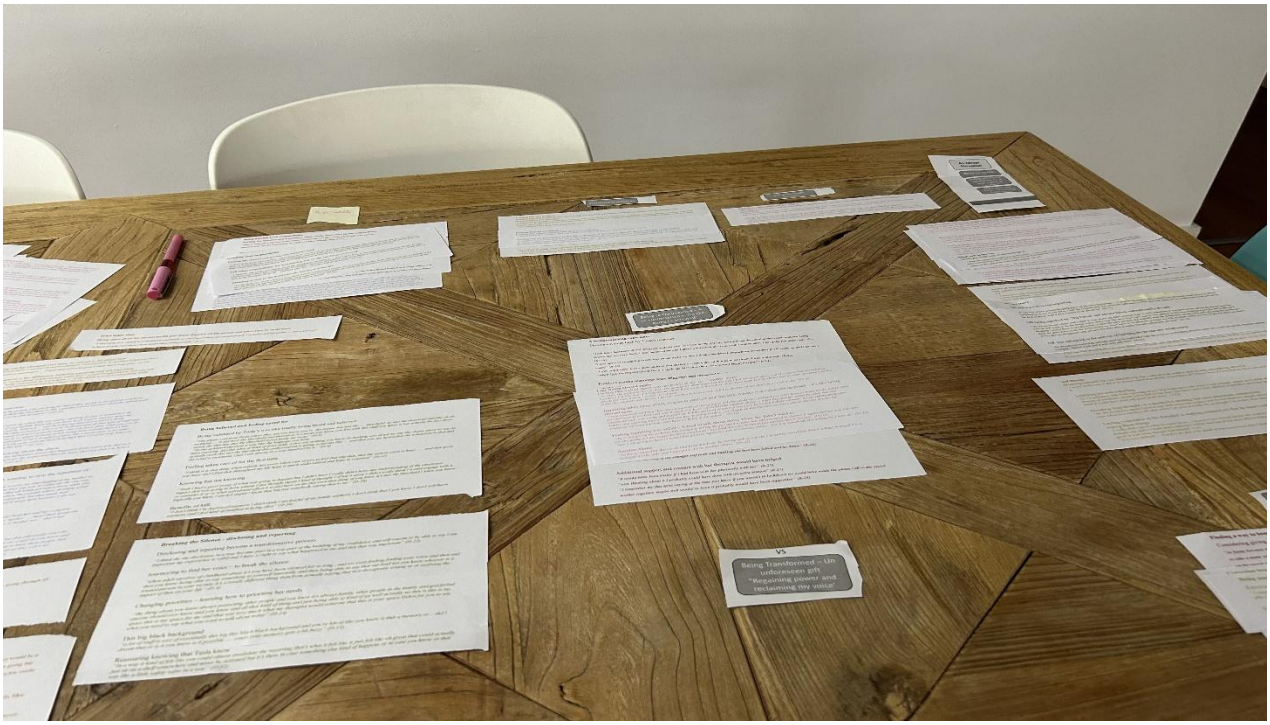
Similar to abuse (e.g. how one person, who abuses their power, could have a devastating impact on his life) and being part of something dangerous to him against his will (e.g. and feeling powerless to protect himself against the authority of Tusla).
"It's the suspicion maybe that this isn't neutral to them, it's sort of, or just handing them ummh nitro-glycerine that they can shake around …. No choice and I feel it's dangerous now …. But its just the feeling, the awareness that somebody could say that we better check does this fella's name has come up anywhere".

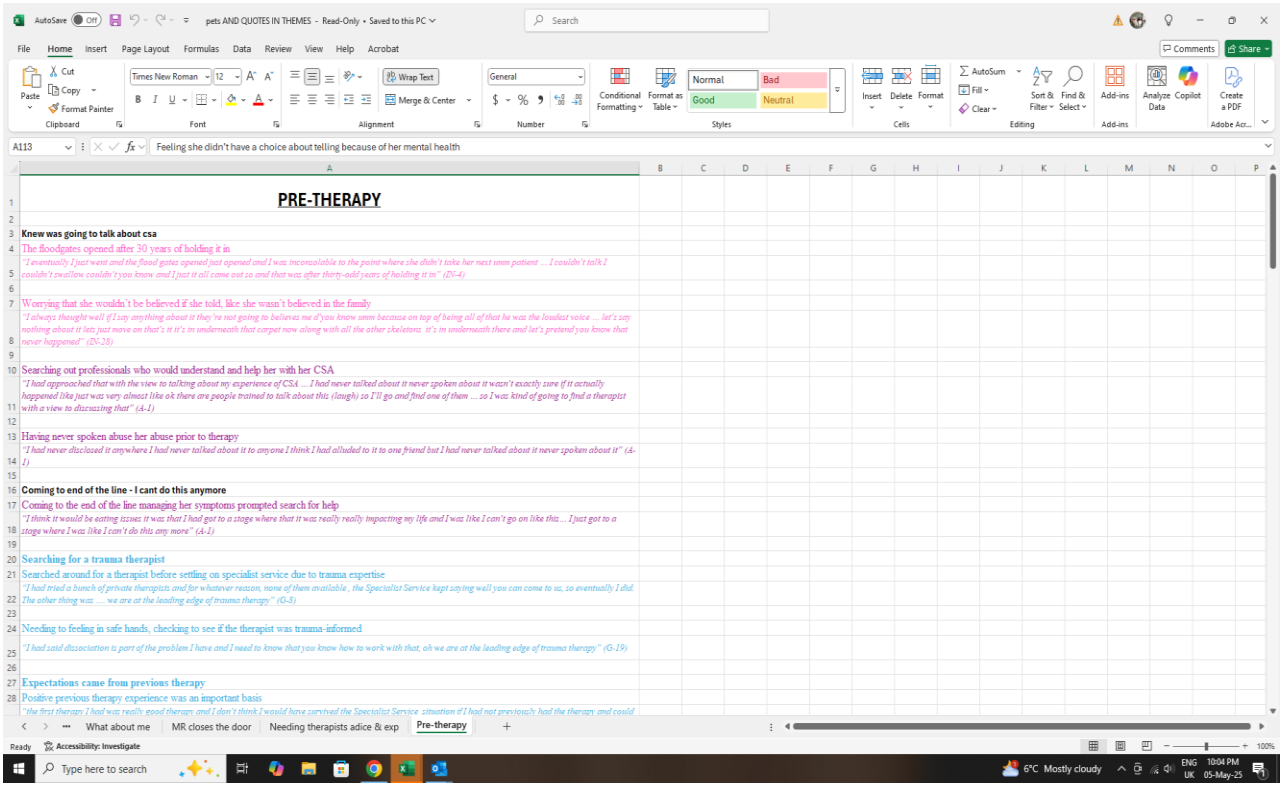
Being aware of the inherent power imbalance in therapy, which is compounded by the reporting (e.g. someone has the right of access to his information, and he has no right to protect it). Preventing him from regaining the power which abuse denied him.
" Yes or I thought that if I said X because I think that part of it too, it's just I mean in my therapy I am not there as the expert and there is a huge element of powerlessness involved in it which is increased when somebody else has the right to the information and I don't have a right to protect it … When you are trying to recover power having been denied it, Ummh I think it screws up an awful lot"

Appendix Q: Creating the GETs









PRE-THERAPY

Knew was going to talk about csa

The floodgates opened after 30 years of holding it in

"I eventually I just went and the flood gates opened just opened and I was inconsolable to the point where she didn't take her next umm patient … I couldn't talk.I couldn't swallow couldn't you know and I just it all came out so and that was after thirty-odd years of holding it in" (IN-4)

Worrying that she wouldn't be believed if she told, like she wasn't believed in the family

"I always thought well if I say anything about it they're not going to believe me d'you know umm because on top of being all of that he was the loudest voice … let's say nothing about it lets just move on that's it it's in underneath that carpet now along with all the other skeletons it's in underneath there and let's pretend you know that never happened" (IN-28)

Searching out professionals who would understand and help her with her CSA

"I had approached that with the view to talking about my experience of CSA … I had never talked about it never spoken about it wasn't exactly sure if it actually happened like just was very almost like ok there are people trained to talk about this (laugh) so I'll go and find one of them … so I was kind of going to find a therapist with a view to discussing that" (A-1)

Having never spoken abuse her abuse prior to therapy

"I had never disclosed it anywhere I had never talked about it to anyone I think I had alluded to it to one friend but I had never talked about it never spoken about it" (A-1)

Coming to end of the line - I cant do this anymore

Coming to the end of the line managing her symptoms prompted search for help

"I think it would be eating issues it was that I had got to a stage where that it was really really impacting my life and I was like I can't go on like this… I just got to a stage where I was like I can't do this any more" (A-1)

Searching for a trauma therapist

Searched around for a therapist before settling on specialist service due to trauma expertise

"I had tried a bunch of private therapists and for whatever reason, none of them available , the Specialist Service kept saying well you can come to us, so eventually I did. The other thing was …. we are at the leading edge of trauma therapy" (G-3)

Needing to feeling in safe hands, checking to see if the therapist was trauma-informed

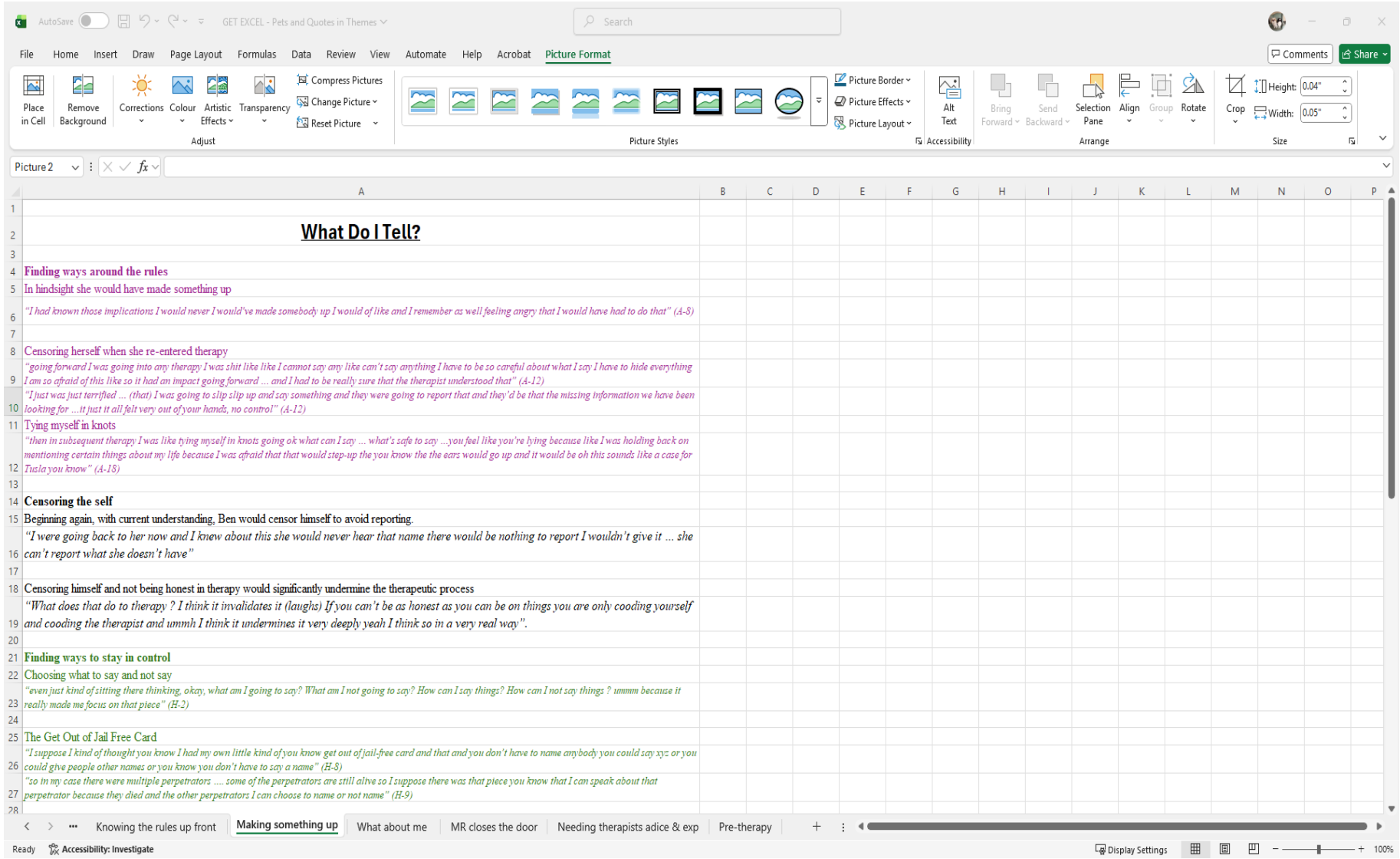
"I had said dissociation is part of the problem I have and I need to know that you know how to work with that, oh we are at the leading edge of trauma therapy" (G-19)

Expectations came from previous therapy

Positive previous therapy experience was an important basis

"the first therapy I had was really good therapy and I don't think I would have survived the Specialist Service situation if I had not previously had the therapy and could

Appendix R: Extracts from Final GET Table



What Do I Tell?

Finding ways around the rules

In hindsight she would have made something up

"I had known those implications I would never I would've made somebody up I would of like and I remember as well feeling angry that I would have had to do that" (A-8)

Censoring herself when she re-entered therapy

"going forward I was going into any therapy I was shit like like I cannot say any like can't say anything I have to be so careful about what I say I have to hide everything I am so afraid of this like so it had an impact going forward ... and I had to be really sure that the therapist understood that" (A-12)

"I just was just terrified ... (that) I was going to slip slip up and say something and they were going to report that and they'd be that the missing information we have been looking for ...it just it all felt very out of your hands, no control" (A-12)

Tying myself in knots

"then in subsequent therapy I was like tying myself in knots going ok what can I say ... what's safe to say ...you feel like you're lying because like I was holding back on mentioning certain things about my life because I was afraid that that would step-up the you know the the ears would go up and it would be oh this sounds like a case for Tusla you know" (A-18)

Censoring the self

Beginning again, with current understanding, Ben would censor himself to avoid reporting.

"I were going back to her now and I knew about this she would never hear that name there would be nothing to report I wouldn't give it ... she can't report what she doesn't have"

Censoring himself and not being honest in therapy would significantly undermine the therapeutic process

"What does that do to therapy ? I think it invalidates it (laughs) If you can't be as honest as you can be on things you are only cooding yourself and cooding the therapist and ummh I think it undermines it very deeply yeah I think so in a very real way".

Finding ways to stay in control

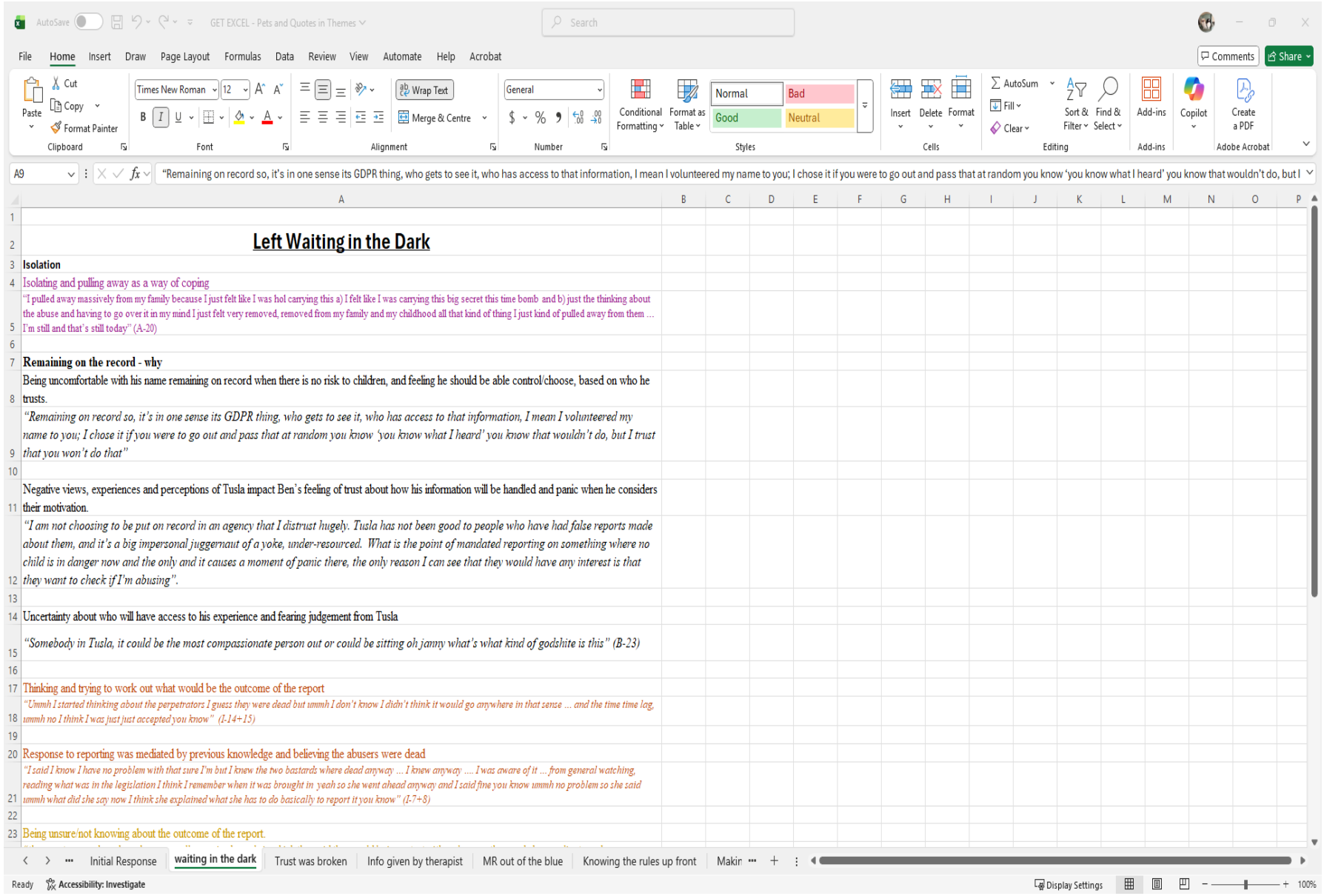
Choosing what to say and not say

"even just kind of sitting there thinking, okay, what am I going to say? What am I not going to say? How can I say things? How can I not say things ? ummm because it really made me focus on that piece" (H-2)

The Get Out of Jail Free Card

"I suppose I kind of thought you know I had my own little kind of you know get out of jail-free card and that and you don't have to name anybody you could say xyz or you could give people other names or you know you don't have to say a name" (H-8)

"so in my case there were multiple perpetrators .... some of the perpetrators are still alive so I suppose there was that piece you know that I can speak about that perpetrator because they died and the other perpetrators I can choose to name or not name" (H-9)



Left Waiting in the Dark

Isolation

Isolating and pulling away as a way of coping

"I pulled away massively from my family because I just felt like I was hol carrying this a) I felt like I was carrying this big secret this time bomb and b) just the thinking about the abuse and having to go over it in my mind I just felt very removed, removed from my family and my childhood all that kind of thing I just kind of pulled away from them … I'm still and that's still today" (A-20)

Remaining on the record - why

Being uncomfortable with his name remaining on record when there is no risk to children, and feeling he should be able control/choose, based on who he trusts.

"Remaining on record so, it's in one sense its GDPR thing, who gets to see it, who has access to that information, I mean I volunteered my name to you; I chose it if you were to go out and pass that at random you know 'you know what I heard' you know that wouldn't do, but I trust that you won't do that"

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Uncertainty about who will have access to his experience and fearing judgement from Tusla

"Somebody in Tusla, it could be the most compassionate person out or could be sitting oh jamny what's what kind of godshite is this" (B-23)

Thinking and trying to work out what would be the outcome of the report

"Ummh I started thinking about the perpetrators I guess they were dead but ummh I don't know I didn't think it would go anywhere in that sense … and the time time lag, ummh no I think I was just just accepted you know" (I-14+15)

Response to reporting was mediated by previous knowledge and believing the abusers were dead

"I said I know I have no problem with that sure I'm but I knew the two bastards where dead anyway … I knew anyway …. I was aware of it … from general watching, reading what was in the legislation I think I remember when it was brought in yeah so she went ahead anyway and I said fine you know ummh no problem so she said ummh what did she say now I think she explained what she has to do basically to report it you know" (I-7+8)

Being unsure/not knowing about the outcome of the report.

Appendix S: The Principles of Trauma-Informed Care

The Six Principles of Trauma-Informed Care	
Safety	Physical, emotional, and psychological security are prioritised
Trustworthiness & Transparency	Open and clear communication and decision-making
Peer Support	Connection with others who share lived experiences fosters healing
Collaboration and Mutuality	Power differentials between client and therapist are minimised
Empowerment, Voice and Choice	Clients are supported to reclaim agency and autonomy
Cultural, Historical & Gender Issues	Practices are responsive to systemic inequities and diverse identities

Adapted from SAMHSA (2014)

Appendix T: Prevalence Table for GET Sub-Themes

GET Title	Sub-Theme Title	Number of participants
Figuring out Disclosure	Making Sense of Why to Tell	9
	Finding Someone to Tell	6
	Deciding What to Tell	7
Living Through a Sudden Upheaval	The Moment of Realisation	7
	Feeling Fear to Terror from Past and Present	7
	Left Waiting in the Dark	6
A Turning Point: Held by the Therapist*	Feeling the Strength of Connection	10
	Facing what Reporting Opens	10
	Needing Guidance	10
	Experiencing Power being Re-Balanced	10
Finding Agency in the Unbearable	Confronting Reality	8
	Carrying the Burden of Responsibility	7

* GET 3 – '*A Turning Point: Held by the Therapist'* operates on a continuum that spans from the experience of re-traumatisation at one end to transformative healing at the other. Three sub-themes—'*Feeling the Strength of Connection', 'Needing Guidance' and 'Experiencing Power as Being Re-Balanced '*- are also positioned along a continuum, reflecting the varying levels of engagement and experience reported by each participant. The second sub-theme, *'Facing What Reporting Opens'*, was universally encountered among participants; however, each individual's experience was distinctive and shaped by their personal context.