Adult survivors and their families: current needs and service responses

Final Report to the National Institute for Social Care and Health Research

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Introduction

Not enough is yet known about the needs of adult survivors of childhood sexual abuse. Sexual abuse is hidden and the distress and shame that survivors often feel prevents many from seeking help. Although there is a plethora of research relating to the effects of childhood sexual abuse and a growing appreciation of the effects this can have on adult survivors, the lack of a co-ordinated approach in relation to service provision, training and policy issues for adult survivors of childhood sexual abuse is problematic (Stern Review, 2010; Survivors Trust, 2010). Thus, the purpose of this research was to provide an evidence base to inform future developments in policy, practice and service provision to better meet the needs of adult survivors of childhood sexual abuse and their **current** families.

From a range of stakeholder perspectives we sought to:

1. Better understand the challenges faced by adult survivors of childhood sexual abuse and *where appropriate* their families.
2. Explore how services (generic and specialist) respond to the needs of adult survivors and their families and consider unmet need.
3. Consider the perceived effectiveness of service responses.
4. Make policy and practice recommendations to improve support to adult survivors and their families and other vulnerable groups.

Method

The work was completed over an eighteen month period using qualitative methods of data collection and analysis. We conducted 30 telephone interviews with managers and practitioners and 30 in-depth face-to-face interviews with adult survivors of childhood sexual abuse.

Key findings

The three key areas arising from the study are:

- Relationships
- Individual life journeys
- Stigma

Establishing and maintaining *relationships* with others is experienced as a challenge by survivors throughout their adult life. Underpinned

by issues relating to trust and seeking safety, these difficulties serve to further reinforce feelings of isolation and, for some, foster a sense of fear, anxiety and impaired self-efficacy. Being believed is critically important at the point of disclosure and thereafter; it is central to the building and maintaining of relationships with others, including professionals, and to the survivor's individual journey.

Whilst survivors describe a number of common experiences, in particular, their sense of guilt, shame and feeling disconnected, their *individual life journeys* (characterised by *seeking support, moving towards healing* and *moving on*) are complex and unique. However, present service organisation and delivery arrangements are often inflexible and lack responsiveness to the individual's lived experiences, personal preferences and priorities. Limited joint working and ineffective signposting compound the situation.

The important contribution of third sector organisations in delivering support is recognised by survivors and staff alike; however current funding deficits mean that the sector is unable to realise its full potential and, despite the best efforts of staff, flexibility and innovation are stifled. There are a number of serious and prevailing gaps in service provision.

Stigma is highlighted as a major issue. The taboo associated with childhood sexual abuse challenges the accepted view of a civilised society which places a high value on the safe care, development and nurturing of children and protection from harm and exploitation. Survivors reflect on the raft on negative emotions they experience; this includes speaking about the pervasive effects of guilt, shame, low self-worth and a disrupted sense of self, which they suggest are inextricably linked to the prevailing stigma associated with child sexual abuse.

Stigma serves as a barrier to accessing much needed help and support. Sometimes the reactions of staff to disclosures of sexual abuse during childhood, as well as their reactions to highly sensitive, intimate information serve to further reinforce survivors' sense of stigma, as do professional expectations of what survivors might aspire to and achieve in their lives.

Health and social care practice tends to be reactive; the focus lies in treating the presenting symptoms and minimising the immediate harm rather than supporting survivors to explore aspects of their sexual abuse history or to develop strategies for coping positively with day-to-day life. This includes strategies for addressing feelings of stigma and shame.

Key implications for policy and practice

Our research findings highlight key areas where the organisation and delivery of services might be improved, as well as priorities for future service development. Areas for service improvement reflect the need to:

Address funding deficits, as reported by third sector organisations

- o This includes pump-priming monies to encourage the development of *new* services as well as resources to fund the much-needed expansion of *existing* specialist counselling services (which survivors praise for their sensitivity and depth of understanding).
- o Funding is required to address some of the main gaps in provision, including counselling for: male survivors; families and significant others; transgender survivors; and perpetrators who are themselves survivors of child sexual abuse.

Strengthen partnership working between key stakeholders

- o A clearer understanding of the roles, responsibilities and complementary skills of respective stakeholders needs to be developed to encourage more effective partnerships and address difficulties relating to inappropriate referrals, as well as encourage the sharing of expertise and good practice.
- o Opportunities to develop joint initiatives should be fostered, for example, via the existing Wales Learning and Improvement Networks (LIN) – including the Citizen Directed Support LIN for Wales and the Housing LIN.
- o In addition we suggest that a specific Sexual Violence LIN for Wales be established to: promote greater collaboration; facilitate discussion of the key issues and challenges affecting those who work in the sexual violence field; raise awareness; encourage the cross fertilisation of knowledge and practice exchange; and develop new and innovative ways of working.

Deliver more flexible and diverse support

- o Innovative thinking around service design and delivery to develop timely, creative responses to individuals in need is required.
- o The provision of on-going support (non-therapeutic) to help survivors in the longer term is important; this includes:
  - • Practical support - for example, help with seeking employment or finding suitable housing.

- Social and emotional support - for example, help with establishing relationships and overcoming feelings of isolation and loneliness.
- Advocacy support - for example, help to understand the benefit system or to liaise with employers about difficulties experienced in the workplace.

- o It would be helpful to explore the potential of local community organisations and faith groups to provide this type of support; this would need to take into account a broad a range of issues, including the level of demand in localities, the requirements for competent performance and sensitive delivery, as well as stringent monitoring arrangements, training and channels of communication between respective stakeholder groups.

Improve choice and respect the personal preferences of adult survivors, particularly in relation to gender and language

- o Change and development is needed at the provider level to create opportunities that make a positive difference.
- o Commissioning organisations must work more closely with survivors to develop responsive provision that is capable of supporting individuals to achieve a variety of *personalised* outcomes, including social and emotional outcomes that are important in shaping wellbeing and quality of life and helping individuals overcome trauma in their lives.
- o Personal preferences, for example, counselling that is sensitive to gender and language preferences and compliant with the Gender Equality Duty (2007) and Welsh Language Act (1993), need to be accommodated.

Promote greater awareness, sensitivity and understanding amongst frontline service providers and the general public of the longer term challenges that *may* affect adults who experience sexual abuse during childhood

- o Steps need to be taken to promote greater awareness, sensitivity and understanding amongst commissioners and frontline service providers, as well as the general public, to help combat stigma.
- o Providers must consider how they might address the poor reputation of statutory health and social care services, in particular, the low expectations some individuals have of receiving sensitive, responsive support and their limited confidence in service provision.
- o Actively seeking opportunities to involve survivors and their families in the development and delivery of training programmes is important in terms of staff gaining a clearer

view of survivor-defined outcomes and the longer term effects of child sexual abuse, as is availing of the expertise of *specialist* third sector organisations.

o There is also considerable scope to learn from existing examples of good practice, such as *Survivors Scotland.*

Monitor the effectiveness of support provided

o Organisations need to actively involve survivors in measuring the effectiveness of policies, initiatives and services that are designed to support them. In particular, organisations should make more concerted efforts to capture survivor perspectives on the *quality* as well as the *quantity* of support received.

o In measuring outcomes, organisations should consider:

- Are services consistent with the priorities and intended outcomes identified by survivors and do they match their expectations?

- Do survivors regard services as relevant and responsive to their individual needs?

- Do services make life easier for survivors and their families, taking into account their coping strategies?

- In what ways might services be improved and the timescales for improvement?

o Recent work by the Survivors Trust (2010) outlines a number of detailed, sector specific outcome measures that might be helpful in terms of monitoring and evaluating the quality and effectiveness of support to survivors and their families.

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We would like to thank the adult survivors who kindly shared their stories with the research team and also the staff who were interviewed.

Chapter 1 Introduction and Background

Introduction

Not enough is yet known about the needs of adult survivors of childhood sexual abuse. Sexual abuse is hidden and the distress that survivors often feel prevents many from seeking help. Although there is a plethora of research relating to the effects of childhood sexual abuse and a growing appreciation of the effects this can have on adult survivors, the lack of a co-ordinated approach in relation to service provision, training and policy issues for adult survivors of childhood sexual abuse is problematic.

This chapter describes the aims and objectives of the research, sets the policy and practice context and also considers the evidence base.

Purpose

The purpose of this research was to provide an evidence base to inform future developments in policy, practice and service provision to better meet the needs of adult survivors of childhood sexual abuse and their **current** families.

Aims

From a range of stakeholder perspectives we sought to:
 1. Better understand the challenges faced by adult survivors of childhood sexual abuse and *where appropriate* their families.
 2. Explore how services (generic and specialist) respond to the needs of adult survivors and their families and consider unmet need.
 3. Consider the perceived effectiveness of service responses.
 4. Make policy and practice recommendations to improve support to adult survivors and their families and other vulnerable groups.

A Project Reference Group, comprising survivors, academics and representatives from statutory and independent sector organisations, informed the research process and will guide the dissemination of findings. It met on three occasions over the course of the eighteen month project. The collaboration with Victim Support brought extensive experience of working with and supporting individuals affected by crime.

Background

There is no universally agreed definition of the term *child sexual abuse*, making it difficult to estimate the number of children sexually

abused. This is exacerbated by the hidden nature of abuse; many children not reporting abuse, or not doing so until they are adults (Cawson *et. al.,* 2000). The Word Health Organization (2006, p. 19) defines child sexual abuse as:

> *"[…] the involvement of a child in sexual activity that the child cannot comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared or which violates the social taboos of society."*

It is difficult to provide estimates of prevalence as disclosure of sexual abuse can be delayed by perceptions of shame and stigma; research suggests that reporting levels are low (Lovell, 2003). It should also be noted that some of the figures (below) are based on retrospective disclosure in adulthood, whereas others relate to disclosure in childhood. This may partly explain the wide variation that can be seen.

One finding, based on asking adults about their childhood experiences, suggests that about 28% of the general adult population have experienced some form of sexual abuse in childhood (McGee *et al*., 2002). Children with disabilities, looked after children and those living in families experiencing domestic violence are thought most likely to be affected (HM Government, 2007). A recent report by Radford *et al*. in 2011 for the National Society for the Prevention of Cruelty to Children (NSPCC) found that 5% of children under the age of 16 years experienced coerced sexual acts in 2009. Other findings suggest that 21% – 33% of females experience some form of sexual abuse during childhood (McGee *et al.*, 2002; Home Office, the Department of Health and the Association of Chief Police Officers, 2009).

Less is known about sexual abuse rates in males and evidence suggests that more females than males have experienced childhood sexual abuse (Radford *et al*., 2011; Weiss *et al*., 1990). Suggested prevalence rates for males range from 2.6% – 25% (Barnett *et al*., 2005; Cawson *et al*., 2000; HO, DH, and ACPO, 2009; Kelly, Regan and Burton, 1991; McGee *et al*., 2002; Nelson, 2009; Radford *et al*., 2011). Research has established that males generally find it more difficult to report sexual child abuse for a range of reasons, including: stereotypes about men being perpetrators of abuse rather than being subject to abuse; perceptions that males should be able to fight and be self-reliant; fears of being perceived as gay; and, pressures to conform to stereotypes by not expressing vulnerability or displaying signs of helplessness (Barnett *et al*., 2005; Stern Review, 2010).

Worryingly, children and young people who are sexually abused are more likely to experience other types of abuse (Radford *et al*., 2011). This pattern is likely to continue through into adulthood (Coid *et al*., 2001; Desai *et al*., 2002; Noll *et al*., 2003; Paul *et al*., 2001). For example, Noll *et al*. (2003) found that adult females with a confirmed history of child sexual abuse report twice as many subsequent incidences of sexual abuse than other individuals.

Policy context

Historically, there has been a focus on domestic violence services and it has been argued that a better understanding of the needs of adult survivors of abuse has only started to develop more recently. Generally, development of services for adult survivors of child sexual abuse is perceived as piecemeal, with services for adult survivors being the poor relation. Policies tend to focus on violence against women and children and do not include or only briefly allude to the needs of adult survivors of child sexual abuse (End Violence Against Women, Rape Crisis (England and Wales), the Child and Woman Abuse Studies Unit and Fawcett, 2008; The Survivors Trust, 2010).

The Savi report by McGee et al. (2002) was the first comprehensive research looking at male and female lifetime experience of sexual violence and the uptake of related services in Ireland. The report was commissioned by the Dublin Rape Crisis Centre as the only figures available at the time were based on individuals accessing counselling or reporting to the police; this hindered the planning of appropriate levels of service development and provision, as well as the development of targeted information campaigns to encourage individuals to access services. This seminal report led to a series of recommendations for Ireland which have wider applicability to other UK regions, including (pp. xli-xlii*)*:

- A comprehensive public awareness campaign on sexual violence be developed, delivered and evaluated.
- A range of information materials on services for sexual violence be developed and made available in appropriate settings and formats to assist those in need of such services.
- Barriers to the disclosure of sexual violence be addressed at the level of the general public, professionals and systems.
- All those responsible for public awareness, educational, health-related or law enforcement service delivery on the issue of sexual violence incorporate information on vulnerability for specific groups in their activities.
- The need for service developments be anticipated and planned on the basis of a comprehensive needs evaluation of evidence for medical, counselling and law enforcement services.

- A range of educational materials on sexual violence in society be developed for relevant professionals; this to complement a national public awareness campaign.
- Regular assessment of the user perspective be incorporated into service evaluation and planning for improvement.
- A systematic programme of research is needed to inform, support and evaluate developments in addressing sexual violence in the coming years.
- A Consultative Committee on Sexual Violence be established with the responsibility and authority to ensure that recommendations arising from the SAVI Study and similar reports are acted on by relevant agencies within an appropriate timeframe.

Over recent years there have been a series of initiatives aimed at improving services and outcomes for survivors of rape, sexual violence and childhood sexual abuse in the UK. This is an important step forward but as mentioned earlier, the needs of adult survivors of childhood sexual abuse often tend to be neglected. A Cross Government Action Plan on sexual violence and abuse (HM Government, 2007) outlined measures to: develop a more strategic approach to tackling sexual abuse; increase access to support; build capacity in services; and, improve the criminal justice response to sexual abuse. This action plan built on other UK-wide documents such as *Saving Lives, Reducing Harm. Protecting the Public* (Home Office, 2008) and its up-date in 2009. Key agencies to deliver the action plan include the police, Local Authorities, Voluntary and Community Sector Organisations, Sexual Assault Referral Centres (SARCs) and Primary Care Trusts (Health Boards in Wales). The Welsh Government's six-year integrated strategy for tackling all forms of violence, including sexual violence, against women and children *The Right to be safe* (2010a) and its implementation plan (2010b), reflects UK-wide developments in a Welsh context. The objectives are: to challenge attitudes and raise awareness; provide support for victims; protect children; improve the response of criminal justice agencies; and, improve the response of health services and other agencies. The focus is on women and children who have an acute experience of violence.

A recent seminal review led by Baroness Stern, *The Stern Review* (2010)*,* looked into how rape complaints are handled by public authorities in England and Wales. The main focus is on current incidences of rape in adults but the Review also addresses service responses to historic cases (survivors of childhood sexual abuse). The main conclusions are that: policies are right, implementation is patchy and must be improved; positive obligations to victims must be recognised; and, although conviction rates are important, support and care for survivors should be a higher priority. The report

concludes that although policies have improved immensely, there are gaps in implementation. The recommendations emphasise the role of SARCs and advocate that they should be expanded and be an integrated part of mainstream provision.

Sexual Assault Referral Centres (SARCs)

SARCs have been developed across the UK and there are six in Wales. *The National Service Guidelines for Developing Sexual Assault Referral Centres* were published in 2005 by the Home Office and the Department of Health. The guidelines emphasise the importance of partnership working between the police, the health services and the third sector to provide holistic services. An up-dated version of the guidelines listing the key elements of a SARC was published in 2009.

These key elements are reflected in the service specification developed by Public Health Wales (PHW, 2010). The Public Health Wales (2010, p.3) definition sets out the services that the SARCs should provide:

> *"A SARC is a 'one stop' location where victims of sexual assault can receive medical care and counselling whilst at the same time having the opportunity to assist the Police investigation into alleged offences, including the facilities for a high standard of forensic examination."*

Each SARC should have a multiagency steering committee comprising of representatives from Health Boards, the police and forensics and third sector organisations (Public Health Wales, 2010). Individuals can self-refer or be referred through the police, health or voluntary sector. The minimum level of service provision outlined in the specification includes:

- Twenty-four hour access, including arrangements for self-referrals, to crisis support, first aid, safeguarding, specialist clinical and forensic care in a secure unit.
- Appropriately trained crisis workers to provide immediate support to the victim and significant others where relevant, throughout the examination process.
- Choice of gender of physician wherever possible.
- Access to forensic physicians and other practitioners who are appropriately qualified, trained and supported and who are experienced in sexual offences examinations for adults and children.

- Dedicated, forensically approved premises and a facility with decontamination protocols following each examination to ensure high-quality forensic integrity and a robust chain of evidence.
- The medical consultation includes a risk assessment of harm/self-harm, together with an assessment of vulnerability and sexual health; immediate access to emergency contraception, post exposure prophylaxis (PEP) or other acute, mental health or sexual health services and follow-up as needed.
- Access to support, advocacy and follow-up provided through an independent sexual violence adviser (ISVA) service, including support throughout the criminal justice process, should the victim choose that route.
- Well co-ordinated interagency arrangements, involving local third sector service organisations that are reviewed regularly to support the SARC in delivering to agreed care pathways and standards of care.
- The SARC has a core team to provide 24/7 cover for services which meets NHS standards of clinical governance and the European Working Time Directive.
- A minimum dataset and appropriate data collection procedures in each SARC.

(Adapted from the Revised National Service Guide, 2009, p. 18)

The specification notes that *although the main role of the SARCs is to support individuals who report an acute/current sexual assault, they are also tasked* to provide referral pathways to support individuals with a history of past sexual abuse. However the document points to difficulties in some areas to provide services for adult survivors due to resource issues:

> *"In some police areas, sexual assault examination facilities are only used a few times each week which means that it may not be cost effective to develop the key service elements, namely: […] provision for meeting the needs of children experiencing chronic sexual abuse and the effects of historical abuse on adults."* (pp. 5-6)

An example of a comprehensive strategy for survivors is the *Scottish national strategy for survivors of childhood sexual abuse* (Scottish Government, 2005). The strategy was developed with input from organisations representing survivors and individuals. Key aims include: raise and improve knowledge and awareness of childhood abuse; ensure joined-up working in mainstream services; improve the lives of survivors; and, develop training and skills for frontline workers.

Effects of childhood sexual abuse

The effects of sexual abuse in an individual's childhood can be profound and long-lasting, affecting their physical and mental health, employment opportunities and relationships with others (Havig, 2008; Sanderson, 2006). Early research focused on the short-term effects on the child, their psychological development and socialisation. Recent work has considered the longer-term effects of childhood sexual abuse, including health inequalities, and how this affects individuals during adulthood (Arias, 2004; Barnyard *et al*., 2004). Largely, this has been through clinical research into the relationship between childhood sexual abuse and post-traumatic stress disorder (PTSD), depression, self-harm and substance misuse (Al Mamun *et al*., 2007; Sikkema, 2006). The effects cluster around a number of domains where survivors typically experience long-term challenges, including: intrapersonal; interpersonal; behavioural; physical; and, sexual (Itzin, 2006; Fergusson, Boden and Horwood, 2008; Friesen *et al*., 2010; Wilson, 2010).

Itzin (2006), taking a life course perspective with a focus on health, puts forward a framework outlining immediate, mediate and long-term effects. This framework proposes that individuals who have been abused in childhood are more likely to: engage in increased high risk health behaviours such as smoking and drinking, experience mental health problems, as well as experience increased sexual relationship violence in adolescence. These problems and behaviours can continue through into adulthood and lead to poor long-term health outcomes. Worryingly, some studies have concluded that childhood sexual abuse is associated with suicidal behaviour in adulthood, particularly in women (Bebbington *et al*., 2009). However it is important to acknowledge that adult survivors of childhood sexual abuse are not a homogonous group and that there are no simple causal relationships between sexual abuse and the later wellbeing of individual adults (Wilson, 2010). Research suggests that 20-40% of survivors report few long-term effects as adults (Finkelhor, 1990).

Research confirms that adult survivors living with the consequences of child sexual abuse are likely to have difficulties forming relationships with others (Friesen *et al*., 2010; Walker *et al*., 2009); they are likely to experience difficulties establishing and maintaining friends or finding a partner. This is often linked to issues around trust and can lead to feelings of isolation and loneliness (Briere and Elliot, 1994).

Coping with the long-term effects of child sexual abuse

Research suggests that an understanding of coping strategies and their role in the long-term functioning and mental health status of individuals who have been sexually abused in childhood is important. Specific interest is focused on identifying coping strategies that are linked to positive outcomes and those that are more likely to be amenable to change (Walsh *et al*., 2010). It is important to note at this point that this approach frames the effects of child sexual abuse, mentioned above, in terms of strategies to deal with the experience of sexual abuse in childhood.

Although coping strategies can be categorized in different ways, it is generally agreed that strategies are either cognitive or behavioural (Lazarus and Folkman, 1984). Attempts to change one's perception of an event is an example of a cognitive coping strategy and taking action to reduce the effect of a stressful situation an example of a behavioural coping strategy. An alternative way of thinking about coping strategies is to distinguish between approach and avoidance coping (Roth and Cohen, 1986). Approach coping (sometimes called problem-focused coping) is about attempting to integrate painful experiences and thus reducing stress, whereas avoidance (sometimes called emotion-focused coping) is about attempting to protect oneself by creating distance from a traumatic experience. Moos (1995) suggested an integration of the different dimensions; he suggested that cognitive and behavioural coping strategies represent the method of coping and approach and avoidance strategies represent the focus of coping.

A theoretical literature review by Walsh and colleagues (2010) on the ways adults cope with childhood sexual abuse indicates that avoidant coping and emotion-focused coping (a facet of avoidance coping which is about regulating one's emotions rather than the stressful event) tend to be associated with psychological distress. In contrast, approach coping is generally linked to positive outcomes (Brandt and Alexander, 2003). Other coping strategies often associated with positive outcomes include building social support networks, seeking to find meaning in the abuse, and developing a positive life philosophy or faith/spirituality. Having said this, Walsh *et al.* (2010) highlight the dynamic nature of coping over time and context, and suggest that in some instances coping strategies that are generally framed as positive may have some negative outcomes and vice versa.

The seminal conceptual framework developed by Finkelhor and Browne (1985) is helpful to understanding the long-term effects of sexual abuse and the development of coping strategies. They propose four dynamic factors that cause trauma: stigmatisation,

powerlessness, betrayal and traumatic sexualisation. Their framework captures the dynamic and unique nature of each individual abuse experience; it highlights that experiences and expectations of stigmatisation distort individuals' self-image and their sense of self-worth. The experience of powerlessness during the sexual abuse may contribute to a general feeling of having no control over one's life. This may be re-enforced if individuals are not believed and their experiences are not validated. Experiencing betrayal may not only refer to the perpetrator, who may have been a trusted adult, but may include family members who did not notice or support the survivor of abuse at the point of disclosure. Feelings of betrayal can carry forward into adulthood if individuals are disbelieved and these feelings may manifest themselves in issues around trusting others. Traumatic sexualisation in childhood may lead to confusion about individuals' sexual self-concept and difficult emotional associations with sexual activities.

Research using this framework suggests that higher self-reported levels of powerlessness and stigmatisation are related to higher levels of guilt and social introversion and that those individuals with higher levels of stigmatisation are more likely to engage in mal-adaptive coping strategies in adulthood (Draucker, 1995; Gibson and Leitenberg, 2001). Draucker *et al*. (2011) have recently proposed a theoretical healing model which emphasises the concept of 'making meaning' of the abuse experience. They argue that there is a need to shift from a coping approach towards a focus on positive growth and healing. The model proposes a range of stages individuals may go through in the healing process.

Disclosure

Although not enough is yet known about the process of disclosure and its consequences, it is clear that negative reactions to disclosure of sexual abuse can have devastating consequences (Ullman, 2008; Wyatt and Mickey, 1987). Most research has been conducted retrospectively and has focused on females. London *et al*. (2005) conclude that the childhood disclosure rate is about one-third and that the average delay between the abuse commencing and disclosure is 15 years. In line with these findings, a more recent review (Ullman, 2008) suggests that about two-thirds of female adult survivors disclose their experiences but often only after several years. In addition, the child's relationship with the perpetrator influences the timing of disclosure. Research suggests that if the perpetrator is related, there is a great likelihood that disclosure is delayed (DiPietro *et al.*, 1997; Sauzier, 1989; Smith *et al.*, 2000).

Hesitation to disclose in childhood and adulthood is linked to: fear of negative reactions of others such as blame and disbelief; not wanting to up-set others (family and friends); feelings of shame and self-blame; wanting to protect the abuser; and, being threatened by the perpetrator (Sauzier, 1989; Sorsoli *et al*., 2008). Some research indicates that disclosure in childhood is likely to be met with negative reactions by close family members (Lamb and Edgar-Smith, 1994).

Factors that encourage individuals to disclose include internal processes, such as distress, and external factors, such as educational programmes. Disclosure is more likely in adulthood and adult survivors are more likely to disclose to friends or therapists (Roesler and Wind, 1994). If individuals disclose in childhood, they are more likely to disclose to a parent (Arata, 1998).

Accessing services

The hidden nature of sexual abuse and the distress and shame that survivors often feel prevents many from seeking help (Monahan and Forgash, 2000). A lack of information about available support and difficulties in accessing specialist services can exacerbate this (HM Government, 2007; Sanderson, 2006; Survivors Trust, 2006, 2010). Whilst evidence underscores the importance of early intervention and multidisciplinary collaboration (WHO, 2004), the challenges of implementing these principles into mainstream, health and social care practice are considerable (Hall, 2000; Havig, 2008). Research suggests that mainstream services fail to address survivors' complex needs; there is a lack of understanding about the nature and long-term effects of adult survivors of sexual abuse in childhood (Havig, 2008; McGregor *et al*., 2010). Others have suggested that there may be a lack of confidence amongst practitioners in working with survivors, even if they understand the issues theoretically (Day *et al*., 2003). Issues around adherence to a medical model in tandem with an over-reliance on prescribing instead of focusing on individuals have been highlighted (Survivors West Yorkshire, 2006).

Havig (2008) emphasises the need for appropriate assessment tools and accessible interventions. Martsolf *et al*. (2010) conducted a review of qualitative studies of how professional services for survivors are perceived by survivors. They conclude that positive qualities of professional services can be grouped into three areas: a validating focus on the abuse, empathic interpersonal interactions and professional competence. They suggest that service provision framed in this way leads to improved outcomes for survivors in terms of functioning, coping, behaviour and mood.

Research findings indicate that specialist training is necessary, not only for practitioners to feel competent and supported, but also for the survivor to receive the most appropriate and responsive support (McGregor *et al.*, 2010; Sanderson, 2006). Our review of the literature confirms that it is unlikely there is a blueprint for how services might be organised given the diversity of survivor experiences. However, all services must be sensitive to cultural and religious beliefs and to the difficulties associated with disclosure (Havig, 2008; Schachter *et al.*, 2004), including language, which can be a barrier to disclosure (HM Government, 2007). They should also take into account the wider family implications of surviving childhood abuse, providing that the survivor is ready to either inform their family or involve them in their support (Sanderson, 2006). Understanding of the challenges faced by individuals whose partner or relative suffered childhood sexual abuse is very limited and evidence suggests that their support needs are often overlooked (Abused, Empowered, Survive, Thrive, 2009).

The contribution of third sector organisations

The importance of third sector organisations, and in particular specialist organisations, has been recognised in a number of policies and strategies (HM Government, 2009; WAG, 2010a). Third sector organisations such as the Survivors Trust and the National Association for People Abused in Childhood (NAPAC) play a critical role in providing a range of specialist, abuse specific services and signposting to other relevant organisations. In addition they can support understanding and practice in the statutory sectors and campaign for change (Itzin, 2006). For example, the Welsh arm of the UK-wide campaign 'S*top it now! Together we can prevent child sexual abuse',* apart from providing a helpline is campaigning for change.

A recent report by the Survivors Trust (2010) looked at the stability, sustainability and capacity of specialist third sector services by conducting a survey of its member agencies. It found that the statutory sector relies heavily on third sector organisations; it accounted for 71% of all the referrals made. However, despite the high referral rates, there is a lack of appropriate funding streams for third sector organizations. This can impact heavily on their ability to plan and deliver services. It is particularly relevant as research suggests that a lack of sensitive and flexible support services may increase the possibility that survivors experience long-term negative consequences (Astbury, 2006).

Chapter 2 Method

Introduction

The work was completed over an eighteen month period using qualitative methods of data collection and analysis. The main research tasks are described in this chapter.

Interviews with strategic and operational staff

Following approval from the South East Wales Research Ethics Committee and endorsement by the Association of Directors of Social Services Cymru, we invited two Local Authority areas (one from North Wales, one from South Wales) to take part in in-depth work relating to the strategic and operational arrangements in place to support adult survivors and their *current* families. One study site was in an urban area, the other a rural area. Our sites took into account a broad range of factors, including language, socio-economic profile and location of Sexual Assault Referral Centre(s).

Interview sample

In-depth interviews were completed with managers and practitioners from:

- Local and national third sector organisations
- NHS
- Local Authorities
- Probation Service
- Police
- Sexual Assault Referral Centres (SARCs)

Staff were nominated by the Chief Executive of their organization because of their managerial or practice-based experience of working with adult survivors. An Information Sheet, describing the study and detailing the areas of interest to be discussed at interview, was sent to staff in advance. In total, we spoke to 30 individuals; this includes 26 face-to-face interviews and 4 interviews that were completed over the telephone. A breakdown of the staff sample is presented in Table 1.

Many of our interviewees (n=22) were based in the third sector. This reflects the fact that much of the ongoing support available to survivors and their families is delivered by this sector. Also, in one of our study sites, one of the SARCs servicing the area is led by the third sector.

Table 1: Staff Interview Sample

Sector	Staff Designation	Number
Third	Strategic Manager	12
	Training and Project Development Coordinator	3
	Volunteer Coordinator	3
	Counsellor	3
	Independent Sexual Violence Advisor	1
Statutory	Health - Psychological Therapist	1
	Social Care – Domestic Abuse Coordinator	2
	Police – Detective Chief Inspector	1
	Police – Detective Constable	1
	Police – Specially Trained Officer	2
	Probation – Project Development Manager	1
Total		**30**

Areas of interest

Interviews were framed by a topic guide that was developed in consultation with a Project Reference Group (see below). The topic guide drew on the most recent research, policy and practice literature that considers the experiences of adult survivors and their families, as well as service responses. It included prompts about:

- Exploring the challenges facing adult survivors and their families and the range of needs of this heterogeneous group.
- Defining professional roles and responsibilities towards survivors and their families.
- Engaging with adult survivors, dealing with disclosures and raising awareness about sources of support.
- Signposting to other organizations and understanding of other organizations' roles and responsibilities.
- Exploring needs, as well as identifying and addressing unmet needs.
- Planning care and coordinating complex cases.
- Considering local services, collaborative arrangements and inter-agency responses, including strengths and weaknesses of services and models of service organization and delivery.
- Provision for Welsh language support.
- Priorities for future service development.
- Existing staff training provision, current training and support needs and how these might be met.
- Examples of good practice which are transferable across service settings.
- Key message to Welsh Government.

The in-depth staff interviews took approximately 1.5 hours to complete.

Interviews with survivors

Interview sample

We completed in-depth face-to-face interviews with 30 adult survivors (aged 18 years or over) of childhood sexual abuse.

Identifying survivors of childhood sexual abuse and undertaking research with them is an extremely sensitive task. We were familiar with the literature on accessing difficult to reach groups (Anderson and Hatton 2000; Benoit et al., 2005), that emphasizes the importance of close community and academic collaborations. We therefore enlisted the help of third sector organizations across Wales to distribute bilingual letters of invitation, information sheets and consent forms to individuals *on behalf of* the research team. Organizations *were not* asked to pass on confidential contact details. A covering letter from the organization, explaining their involvement in the project, was included in the mailing. In addition, we launched a website appeal via the National Association for People Abused in Childhood (NAPAC).

We adopted a pragmatic approach to recruitment; the sample included both male and female adult survivors across a broad age range, as well as those who had experience of the criminal justice system and those who had not. Individuals who were currently involved in criminal justice proceedings were excluded from this study so as not to prejudice the outcome.

The information sheet made explicit the focus of the study; participants were asked to reflect on their *current* circumstances and *were not* asked to recall details of events that took place in their childhood. It made clear that participation in the study was voluntary, that individuals were free to withdraw from the study at any time and that their involvement or their withdrawal would have no effect on any support they received. Individuals wishing to take part completed the consent form and returned this directly to the research lead in a freepost envelope. Those individuals responding to the website appeal returned their completed consent form to a secure project specific email account accessed only by the project lead, research officer and research secretary. Individuals consented to their contact details being stored on a confidential database and for a member of the research team to make contact with them to talk about the study and to schedule an interview. This two pronged method of recruitment proved extremely successful; we had originally planned to interview up to twenty adult survivors. Thirty consented to involvement and they were all interviewed.

Following advice from the Project Reference Group, interviews *were not* completed in the individual's own home as originally proposed; instead, they took place by mutual agreement at public buildings, for example, the offices of key third sector organizations. Most (n=25) of the interviews were completed in Wales. However, five interviews were completed in England as individuals had moved.

Given the extremely sensitive nature of the work, the offer of post-interview support (via the NAPAC Helpline or one-to-one counselling) was raised with each research participant. An Information Pack, with contact details of national organizations that offer support to adult survivors, was left with each participant at the end of their interview.

Areas of interest

The interviews with survivors used a narrative approach and stories were elicited using the biographical narrative interview method (BNIM) developed by Wengraf (2011). Narrative approaches have been shown to be very effective with vulnerable groups and for exploring sensitive topics (Holloway and Freshwater, 2007; Rapport *et al.,* 2010), in particular, they enable participants to define what is relevant to them and determine the length of time devoted to a sensitive issue (Birch and Miller, 2000; Goodrum, 2007; Johnson, 2002).

Each interview was conducted in three phases. In the first phase a generative question was asked to elicit an uninterrupted narrative:

> *As you know we are interested in the lives and experiences of adults who have survived sexual abuse in childhood. In a moment, I am going to ask you to please tell me your story: all the experiences and the events that have happened during your adult years and are important for you personally. We don't need to know the details of the abuse.*
>
> *Start wherever you like and take all the time you need. I will listen and I won't interrupt you. I'll just take some notes in case I have any further questions for after you have finished telling me all about it.*
>
> *So, can you please tell me your story as an adult who has experienced sexual abuse as a child – all the events and experiences that have been important to you personally during adulthood? Please start wherever you like and take all the time you need.*

In the second phase the interviewer asked questions to clarify and/or extend issues raised in the narrative and in the last phase specific questions around accessing services and support were asked. This approach enabled the interviewer to be sensitive to the emotions of the participant and flexible in the light of hitherto unthought-of issues. The interviewer was vigilant in anticipating problems and offered rest breaks. On average, interviews took 1.5 hours to complete.

Whilst some participants did become upset during their interview, evidence suggests that participation in a research interview can be a positive experience, enabling individuals to express their feelings and reflect on areas of their life where they have overcome adversity (Lowes, 2006). Subsequent email messages, sent by participants, confirm this and highlight the sensitivity and appropriateness of the narrative approach we adopted. For example:

> *For the first time in my life, someone asked me what I would like regarding services without having "attitude" or ignoring what I was saying […] Thank you and Dr. Seddon for giving me the chance to tell some of my story and giving me the opportunity to make some suggestions about what might work.*

Interviews with current family members or significant others

In the original project proposal we planned to conduct interviews with family members and significant others. However, this was not possible. The stories told by adult survivors highlighted the devastating effects that a disclosure of child sexual abuse often has on family relationships and relationships with others. Whilst some participant information packs (n=8) were left with adult survivors to pass on to a family member or significant other, in most cases it was not appropriate to broach the possibility of their involvement in the study; we received no responses from the packs that were handed out.

Data recording

We recorded the interviews where the participant's written consent was given (n=27). Field-notes served as a back-up to the MP3 recordings. Both were transcribed with the exception of identifying information. Where consent to record was not given, the interviewer took detailed notes and verbatim responses were recorded in italics.

Data management and analysis

Detailed readings of the interview transcripts helped establish a familiarity with the data and encapsulate the emerging themes. An outline coding scheme to highlight what Patton (1990) refers to as *units of meaning* was devised. A series of codes (free nodes) assigned a conceptual label to sections of transcript. The codes were generated *a priori* based on our understanding of the literature and from preliminary readings of the transcripts. The range and variation of themes was mapped using data displays (Richards, 2005). Further refinement of the themes was undertaken in discussion with the Project Reference Group. More detailed analysis allowed for the identification of commonalities and contrasts and resulted in a more complex coding framework represented as hierarchical code groups (tree nodes). Team discussion about node definitions and patterns in the thematic analysis facilitated the interpretation of the data.

Data was entered on to QSR Nvivo 8, which enables researchers to electronically organise qualitative data into themes so that it can be effectively searched and analysed by category. Nvivo 8 facilitates the development of inductive and deductive approaches to data and supports the sensitive exploration of themes.

Our *initial* and *continuing* analysis considered each data set separately. *Final* analysis synthesised the datasets generated from the interviews with survivors and staff, enabling contrasts and comparisons to be made and the exploration of salient themes. For example, where staff perceived the gaps in support and where survivors perceived these to be. Data displays facilitated this process, as recommended by Creswell and Plano-Clarke (2007), and helped to ensure that the findings are as comprehensive as possible in terms of making recommendations to shape future policy and practice.

Ethical considerations

We recognise the extremely sensitive nature of the work and were mindful of the need to pay close attention to ethical considerations, in particular the welfare of study participants and researchers employed on the project. The research was guided by an ethical protocol agreed with the South East Wales Research Ethics Committee and the Association of Directors of Social Services Cymru. Also, we were guided by the ESRC Research Ethics Framework (2010), which sets out the requirements for good practice and high ethical standards.

Privacy and confidentiality are essential to the interview process, providing a framework of trust to explore potentially difficult issues. Participants were given assurances about confidentiality and anonymity. However, the Participant Information Sheet stipulated that in some circumstances it may be necessary to disclose to a third party information which suggests that the participant or another individual is at risk of harm. This included information shared during the staff interviews that were suggestive of malpractice. At the outset, the interviewer made explicit the confidentiality boundaries of the interview and that information suggestive of serious risk would be forwarded to a nominated contact point in the Local Authority Social Services Department.

We made every effort to minimize risk to participants; interviews were completed by team members with considerable experience of interviewing vulnerable individuals and discussing sensitive issues. Participants were asked to reflect on their current circumstances and *were not* asked to recall details of events that happened in their childhood.

Data was anonymised and stored in accordance with data protection requirements. Adequate physical and electronic security of data was ensured by using locked filing cabinets for the storage of signed consent forms and password protection on all computers used, even though identifiers were removed. Data was accessed only by the research team. Participants will not be identified in reports, publications or other outputs arising from this study.

In line with good practice which suggests that researchers should be given opportunities to discuss the challenges and burdens of fieldwork (Watts, 2008) interview de-briefing sessions were conducted by the project lead.

Project Reference Group

User involvement is a key determinant of policy impact (ESRC Strategic Plan, 2009-2014); it is critical to the development and conduct of research that addresses issues which are most important to adult survivors. A multi-sectoral Project Reference Group (PRG), comprising survivors and representatives from statutory and third sector organizations, was established with the aim of involving key stakeholders in the research process. Members were recruited via our academic and practice networks. The PRG met on three occasions, in an accessible venue, and members were invited to comment on:

- The development of interview topic guides.

- The analysis of research data, for example, the interpretation of emerging findings.
- Policy and practice implications, including their relevance, sensitivity and responsiveness.

Whilst there is no blueprint for successful involvement, the Service User Research Group England (SURGE, 2005) outlines a number of key principles for collaboration; these underpinned our work and included:

- Clarity and transparency – researchers need to be clear why they are seeking involvement and people need to be clear why they are taking part.
- Respect – everyone taking part should respect each other and the right to express their own views.
- Diversity – researchers need to take account of the diversity of the population they serve when seeking to build capacity amongst local service users.
- Accessibility – researchers need to use plain language and avoid jargon.

At the outset, PRG members were given a short information booklet that explained why their involvement was important, detailed their likely contribution and clarified the resources available to support their involvement. PRG members were encouraged to share their own personal experiences and to also contribute a wider consumer perspective, as recommended in the literature on consumer involvement (Buckland and Gorin, 2001).

In line with the principles of good practice (Department of Health, 2006; Involving People, 2009), members travel expenses were paid.

On completion of the study, PRG members were given the opportunity to feedback about their involvement. In particular:

- Did they feel that their involvement made a difference to the research?
- Could the research team have used members' skills and experiences more effectively?

This information will help to inform the development and implementation of future collaborative work.

We shall actively seek opportunities to jointly disseminate the research findings with PRG members.

Chapter 3: A life journey - the experience of childhood sexual abuse from an adult perspective

Introduction

This chapter presents the main findings from the narrative interviews with adult survivors of sexual abuse in childhood. We reflect on how individuals make sense of their experiences and use coping mechanisms over the course of their lives. Although the narratives were highly individual, common themes emerged from the interviews.

It is important to remember that although many people who have experienced sexual abuse in childhood live successful lives, many also experience a range of negative consequences during adulthood (Polusny and Follette, 1995; Walker, Holman and Busby, 2009; Wilson, 2010). Individuals' responses to sexual abuse in childhood may vary over time and research has shown that recovery or healing is a dynamic and complex process (Oaksford and Frude, 2003).

The abuse in context

We used a narrative approach (described in Chapter 2) to gain an insight into survivors' experiences and to explore how they make sense of their lives as adults. This meant that we did not explicitly ask survivors to talk about the sexual abuse itself. However, most survivors alluded to the abuse experience(s) and their childhood to make sense of their unfolding lives, albeit to varying degrees.

Although there is a common view that children are sexually assaulted by strangers, research evidence suggests that most sexual abuse is perpetrated by someone known to the child. This tends to be a family member, friend or someone the child comes in regular contact with (Sedlak *et al*., 2010). Not all the survivors participating in the study identified the individual that sexually abused them but those who did (n=25) all referred to someone known to them. Generally this was a father, step-father, their mother's new partner or an uncle. A brother or step-brother was mentioned three times and a mother once. In line with other findings (Higgins and McCabe, 2001), several survivors mentioned multiple types of abuse and neglect in the family such as emotional or physical abuse. The abuse took place in childhood and over varying degrees of time.

Research shows that individuals who have been sexually abused as children are at increased risk of re-victimisation (Coid *et al*., 2001; Desai *et al*., 2002). Findings from the current study concur with

this: individuals were likely to be vulnerable to further additional sexual abuse and rape throughout periods in their lives. In contrast to the earlier abuse, perpetrators tended to be peers or partners:

> *And he was just so abusive. […] this man was oh you know – […] and yeah I'll look after you. So I am looking after him, looking after the children. And he was just – oh well a psychopath. But I think I allowed myself to walk into it.*
> *Survivor 35.1*

Unfolding lives

The narratives of participants give a sense of how their lives unfolded from their teens to adulthood. Most survivors also referred back to events in their childhoods. The following diagram provides an overview of the unfolding lives of the adult survivors we spoke with.
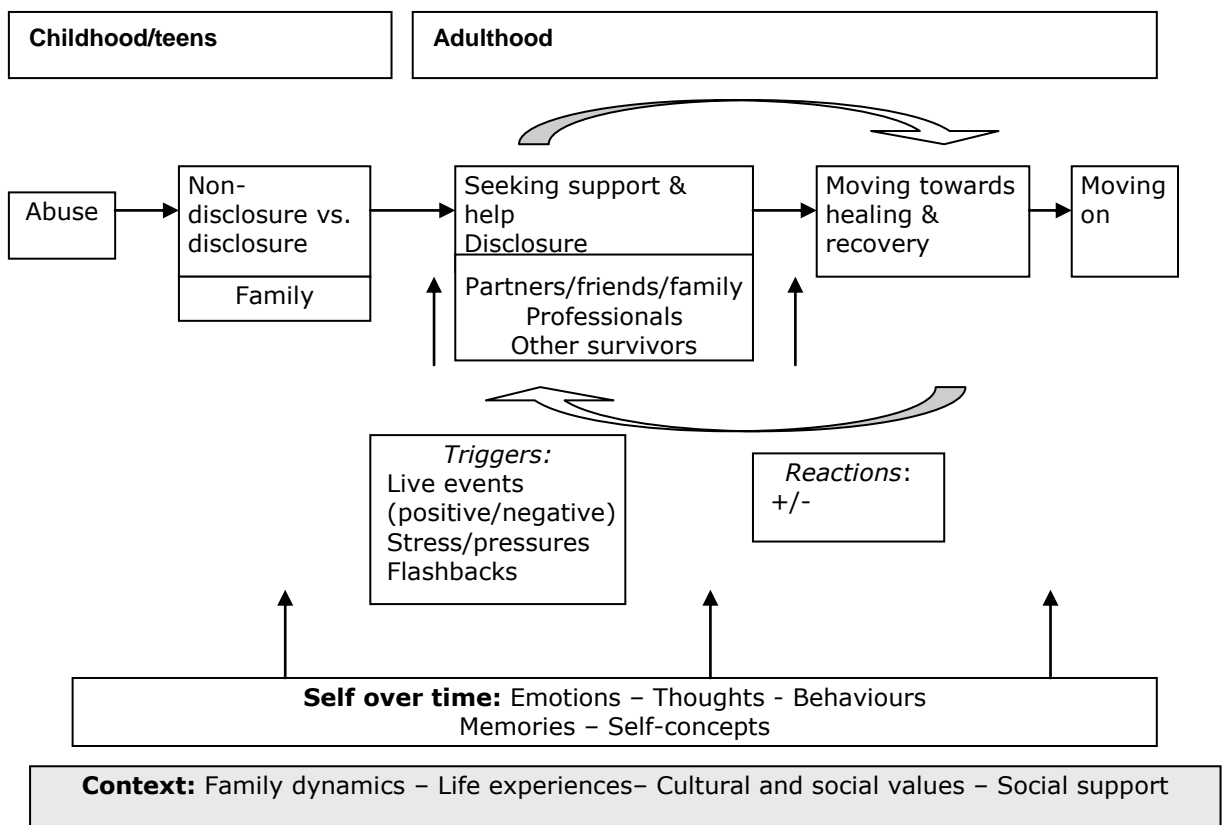

Figure 1: Unfolding lives

The top of the diagram presents the lived life from the experience of the abuse in childhood to moving on towards healing and recovery in adulthood. However, it is important to emphasise that this is not a straightforward journey and that there is a great likelihood that

individuals' move back- and forwards between *seeking support and help* and *moving towards healing and recovery* before *moving on*.

The self changes over time and is reflected in emotions, thoughts and behaviour patterns, memories and self-concepts. Underlying conditions such as family dynamics, the life experiences of a survivor at certain stages, their own and societal values and finally social support systems also play an important role.

Most survivors report having disclosed the abuse in their childhood or teenage years to a family member. As disclosure tended to be met with disbelief, blame or being told to 'get over it', individuals were likely to suppress memories of the abuse:

> *You're told as a child to shut up, you're trained, that's the first thing they will tell. It was – and of course your fam – my family was utterly ashamed of me, I mean they were the ones that put me in there [psychiatric unit] in the first place, they were just ashamed of me.*
> *Survivor 5.1*

Only one survivor, who was also the youngest in our sample (early twenties), disclosed as a child to her mother who took immediate steps. Some survivors did not disclose the abuse when it happened for a range of reasons: some did not realise at the time that this was not 'normal behaviour' and trusted their abuser; others were averse to doing so. Reasons for reluctance included fear, self-blame or expectations of non-belief:

> *If I said anything, then he would, always said 'you'll never wake up in the morning'.*
> *Survivor 22.1*

However, at some point in their adult lives positive or negative life events or pressures brought the abuse experience to the fore. This meant that individuals had to deal with the memories of the abuse in some way. Survivors report suffering from flashbacks and nightmares, that is disturbing sudden memories from the past, to varying degrees. Survivors describe them as very distressing and disruptive as they are 'uncontrollable'. Our analysis suggests that there are two groups of survivors: some experienced flashbacks relatively early, in their late teens and early adulthood and others who did not experience flashbacks until later on in their lives. Survivors who experienced flashbacks later in life tended to have buried their memories very deeply and the flashbacks came as an enormous shock:

And I thought I need a qualification. I want to be counsellor. […] Whilst on the introduction course – and we were dealing with child sexual abuse…. Was when I started getting the flashbacks. I thought they were figments of my imagination. […] I actually counselled somebody and abuse happened to them. And he mentioned […] and that was the room that I had been having flashbacks about. And that's when I knew that this was real. I screamed like I have never screamed. I don't know how long I screamed for. And I just - well I just screamed and I just cried. And my body was shaking. And it went on … it felt like hours and hours and hours. And that's …that was my first big, big realise that this had… this flashback…this had really, really happened to me.
Survivor 35.1

Examples of events that triggered memories of the abuse include: inappropriate abusive behaviour by others (such as abusive language), seeing or hearing something about sexual abuse (in the media or from others), having a male child, having intercourse with a partner, conflicts in the family, as well as joyful and safe experiences such as worshipping in church:

It was a very enjoyable time in worship, in church that I had my first flashback and it knocked me for six and I started crying.
Survivor 17.1

Some had buried the memories so deeply, that they were completely overwhelmed when they experienced flashbacks; these individuals tended to have struggled with their lives, not understanding why:

It all started when I was a teenager, because ever since I was a teenager I was interested in what was wrong with me. […] I was very unhappy in my marriage and I just couldn't figure out what was wrong with me. […] So I was on the search, it was always in my mind, because I was getting so angry and just really depressed and suicidal.
Survivor 14.1

Some narratives suggest that experiences at disclosure are linked to memory. Disbelieve at disclosure can lead individuals to question their memory as these extracts from the survivor accounts illustrate:

[…] I just wasn't believed by people, obviously by the staff (in a therapeutic community). I wasn't believed by the social worker I had at the time. […] Until I came to (counselling organisation) I actually didn't believe that what had happened,

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had happened. […] I still just can't sort of believe that it happened.
Survivor 12.1

I have gone through a lot of my life doubting that what I experienced was abuse […] and I've doubted that I guess because I have had my family, who I've tried to talk about it, over and over again. I have got three brothers and then mum, who is not with dad anymore and they just won't have it.
Survivor 20.1

Accepting that one might need help is a difficult step, in particular as issues such as stigmatisation and stereotyping surround sexual abuse (Finkelhor and Browne, 1985; Gibson and Leitenberg, 2001):

And then, I suppose when I was in my early thirties, I became quite suicidal, but again didn't tell anybody, couldn't approach the doctor. I was going to be labelled as neurotic and silly and pull yourself together.
Survivor 9.1

Survivors mention issues around stigma and stereotyping not only in relation to friends and communities but also professionals, and in particular, mental health professionals:

To be um, to be perfectly honest, um, the mental health team, they don't, um, er, er, it's really weird, it's like they don't like to discuss, um, sexual abuse. … It's a sort of – and you – it's like you mention it and they – they try and sort of quickly change the subject, you know. […] I mean, it's a taboo subject for everybody, you know, it's like mental health, it's a taboo subject, you know.
Survivor 13.1

And um, and I think once that you reveal that you've been abused, people – there's this – there's this myth that anybody who's been abused is going to be an abuser themselves, which I mean most – most people aren't who've been abused, but you automatically feel bad anyway. […] there's a tendency to think, well mental patient, just making it up or they (mental health professionals) – they won't believe you. […] and they're (mental health professionals) happy to go along with it – they're happy to go along – more happy to go along with the abusers who, you know, have got these responsible positions in society, how could it be that anything that a so-called mental patient is telling you is the truth? […] I think when people have been abused, especially in childhood, you know,

> *it's – it's part of a wider problem, it's part of society's attitude towards it as well, because society is happy to close its eyes to a lot of what's going on, you know.*
> *Survivor 5.1*

Some staff talked about stigma and stereotypes in the interviews and highlight public attitudes such as '*this sort of thing does not happen here*' or '*pull yourself together it was a long time ago*'. We explore barriers to seeking support in Chapter 4.

Self over time

Sense of self refers to an individual's experience of their place in the world as an individual and as a member of communities. Individuals are challenged to develop the capacity to establish and maintain a multifaceted, integrated and realistic sense of self (Luke and Stopa, 2009). Emotional, thought and behavioural patterns are connected to the sense of self. Research findings indicate that adults who have experienced sexual abuse as children are more likely to have a disrupted sense of self and that integrating self-concepts and developing a positive identity are part of the healing or recovery process (Murthi *et al.*, 2006; Saha *et al.*, 2011).

Emotions, thoughts and behaviours

Traumatic experiences in childhood, such as sexual abuse, alter thoughts and emotions about the world and are linked to behaviours (Finkelhor and Browne, 1985; Liem and Boudewyn, 1999; Saha *et al.*, 2011). Survivors mention a range of negative emotions, thoughts and self-destructive behaviours in their narratives. In order to change these, individuals have to become aware of these patterns and develop insight into what causes them.

Our analysis suggests that the most persuasive effect of childhood sexual abuse is a sense of low self-worth and low self-esteem. Issues around self-worth and self-esteem are also highlighted by staff. Although these are not emotions themselves, they have a very strong link with emotions. For example, research suggests that feelings of low self-esteem and self-worth are linked to levels of anxiety, shame and unhappiness (Brown and Marshall, 2001). Low self-esteem and self-worth is mentioned by all survivors as influencing their thoughts and behaviour patterns:

> *Well, sort of, I think it's a sort of like a long history of having a lot of depression and anxiety and just total lack of confidence and feeling worthless.*
> *Survivor 5.1*

Feelings of guilt and shame are mentioned by all survivors. Survivors wondered if there was something they did to bring about the abuse; that they should have been able to stop the abuse. They felt ashamed about what happened to them and other people knowing. Feelings of guilt and shame are linked to devaluing oneself and to stigmatisation (Finkelhor and Browne, 1985). These feelings of guilt and shame can inhibit disclosure or seeking help:

> *I'm trying to think, it – because it happened, you think, well, you deserved it, so everything else that happens to you afterwards is because you're a bad person, because you let this happen to you, you know. So you are always looking – you are always looking on the dark side, on the black side.*
> *Survivor 13.1*

Feelings of pain, rejection, and loss were experienced by all survivors. These feelings may be on-going over years or come to the fore when individuals come to acknowledge and accept that they have been sexually abused in childhood:

> *I've not experienced what other girls have – it's the ONLY thing that I can remember from my childhood.*
> *Survivor 24.1*

Linked to these feeling of pain, rejection and loss are feelings of anger and betrayal. Survivors report that anger about the abuse and what happened to them often festered under the surface for years. This includes anger and frustration directed at professionals and family who did not pick up on what had happened earlier on:

> *So I think that, that things could have been different for me [..] would have been hmmm, people flagging up that I had a mental health issue at school, hmmm, and behavioural problems. The police, from being arrested and stuff, when I was a teenager, hmmm, always blind drunk, always smashing things up, hmmm, again there was no examining of the reasons why I was doing that, hmmm, the medical people, if my ulcer keeps bleeding because I'm drinking so much, and I keep having panic attacks and depression and anxiety, no-one ever asks what it was. So things like that let me down. The school let me down. My mum and dad let me down. The doctors let me down. To some extent the police let me down. […] I would have thought that ideally someone would have said look, you know, what have you been doing, and why have you been doing it?*
> *Survivor 23.1*

Anger might be expressed in verbal or physical confrontations with others or directed inwards:

> *Was out there [digging in the garden] until midnight on one occasion just, it was just sheer, sheer temper but I couldn't control it, could not control it. And I'm not an angry per – I'm not that kind of person, but it – I scared myself and I scared other people when – when I just, well I scared my wife and my son when I erupted with it. And er, I couldn't – I couldn't control it, and that was the frightening thing. And it was – it was everybody, they should've protected me, they didn't, you know, I – and that's why I was venting my anger, hmm.*
> *Survivor 22.1*

> *When I left school at sixteen, my coping mech – mechanism became, um, I'm going to hurt you before you hurt me sort of thing. Um, sort of aggressive and um, it was like, I suppose you could describe it like, um, I wasn't being – I wasn't prepared to be hurt again.*
> *Survivor 13.1*

As the above quote illustrates, issues around power and control play an important role. The experience of sexual abuse as a child is experienced as powerlessness and powerlessness is linked to fear and anxiety levels; this impacts on individual's coping skills (Finkelhor and Browne, 1985):

> *It's just not – it's not being yourself, it's not having any control over your body, someone else is controlling, is in control over that, um, and yeah, it's almost like you're some sort of empty shell of a person that is functioning towards one goal and that, you know, that one goal certainly isn't being yourself in a way that a child or a teenager does and is, you know.*
> *Survivor 8.1*

Survivors felt that they had no control over what was happening to them at the time of the abuse and this feeling of powerlessness often transfers itself across into other areas of their lives during adulthood, for example in relationships:

> *If I wanted a job he'd say no we've got enough to do looking after three kids. You stop at home. He was quite happy… because he was a control freak, he was quite happy. To have me in that environment like… It's only now since I am on my own that I realise how controlled I was. But I also think, I let*

that happen because I was controlled with the sexual abuse when I was a child. So that's all I knew, was to be controlled.
Survivor 32.1

For some, 'being in control' or having a sense of power is very important in their adult lives and narratives suggest that some individuals invest considerable effort to be in control; any external threat to this is frightening:

When doing my placements, I always found it really hard, but even like going away for the weekend, like staying anywhere other than my own home, like that freaks me out as well, because it's kind of like I'm not in control of the situation. I don't really know the environment, so I don't know if I'm safe. It's more about kind of – yeah, I suppose it's about being safe and in control really and having somebody else being in control of me, like going somewhere new, or like a new job or something. It's like, I don't know, I just find it quite difficult.
Survivor 6.1

I'm a bit of a control freak and I think that is a by-product of the abuse, it's – you need to be in control.
Survivor 17.1

All individuals mention negative thoughts about the self and several talked about the negative impact of dwelling on the abuse. This is often linked to thoughts such as 'what if?' and 'why me?':

I ask myself everyday 'why me' 'why did this happen to me, what did I do wrong?', 'what did I do to deserve this?'. You pick holes in who you are and your whole identity, your appearance, everything.
Survivor 30.1

Several of the survivors report feelings of alienation or thinking about themselves as 'other' due to their experiences. This is linked to expectations of stigmatisation. The feeling of being different to 'normal' people reinforced their isolation:

The other thing about the group sessions. It was … er … where we all started talking about ourselves, about things … you just don't tell other people. And … we felt normal. We did feel like we were a freak. Which is why we were there in the first place. Because we weren't right, we weren't normal.
Survivor 19.1

I carried all this with me until I was forty; I had it in my head all that time until I had a breakdown. It was only then that I started understanding why I was like I was. Before that I thought I was some kind of freak. That's quite a thing to carry with you in your head all that time.
Survivor 29.1

All survivors talk about negative behaviours and behaviour patterns. Two reoccurring themes are promiscuity and abusive relationships. Periods of promiscuity tended to occur in early adulthood whereas several survivors entered a series of abusive relationships over longer periods of time. These relationships tended to include sexual, emotional and sometimes also physical abuse. Narratives suggest that promiscuity and abusive relationships are linked to feelings of worthlessness, to experiences of only being valued for sex as children, or from a lack of appropriate physical contact and care in childhood. In addition, these relationships recreated familiar emotional and behavioural patterns:

I then went on a – a spree of one-night-stands and er, I think, I had no respect for myself, my body and um, I put it in a context to myself that it's alright for men to do it, so why shouldn't I […]. But looking back now as I've got a lot older, um, there was no sort of respect for myself and my body.
Survivor 17.1

I've been married four times and divorced four times, all bad relationships, which is why I divorced, emotionally unavailable men, from abusive relationships – had really bad depression at times, terrible loneliness, feeling alone.
Survivor 10.1

Survivors of childhood abuse may need to learn how to set and maintain appropriate boundaries to prevent exploitation, disrespect or further emotional or physical abuse (Noll and Grych, 2011).

Other common negative behaviour patterns that individuals report having either engaged in for a long time or at stressful periods in their lives were alcohol and/or drug usage. Some referred to self-harm, that is cutting or physically injuring oneself, and issues around food and eating. Suicidal thoughts or attempted suicide at some points in individuals' lives were also mentioned:

It's hard to say what my life was like. I was using alcohol a lot. I self-harmed. […] I was very isolated throughout, well probably since I was 12 or 13. I never went out anywhere.
Survivor 21.1

I knew that I was like – my eating was out of control … […] and all of the, um, the – the same feelings, we've got bulimics and anorexics in our group as well as compulsive overeaters and all the feelings and inadequacies are exactly the same, it's just how you deal with it, and I guess it's the same for people that turn to drink, er and drugs, er, it's that same sort of um, feelings there.
Survivor 17.1

Individuals reflected that they had engaged in these behaviours in order to forget what had happened, to suppress and cope with overwhelming feelings of distress, or cope with flashbacks and nightmares. At the time they were not always aware of why they were engaging in certain behaviours. Staff also talk about negative behaviour patterns and highlight their possible role as coping strategies which may, to an extent, assist daily functioning.

Some survivors struggle with addictions into later adulthood. At the time of the interview, all who were talking openly about their addictions were members of groups such as *Alcoholics Anonymous* (AA) or *Overeaters Anonymous* (OA) apart from one.

Research shows links between mental health and sexual abuse in childhood (Fergusson *et al.*, 2008; Spataro *et al*., 2004) and this is reflected in our study sample: several survivors mentioned bouts of depression, paranoia and hearing voices as well as phobias. Bouts of depression tend to be linked to times of particular stress or when experiences trigger memories of the abuse. Phobias tend to be longer-term conditions whereas feelings of paranoia and hearing voices are linked to times of stress. Some survivors had been diagnosed with a severe mental illness such as bi-polar disorder and were under the care of a community mental health team:

I mean I suffered from depression ever since I can remember […] I had all these emotions inside me. […] I could not really explain what they were. I felt angry. All that pressure, I always felt angry. But I never knew why. So…er… I started drinking.
Survivor 20.1

I think my experiences as an adult, we're talking post school, have been largely centred around depression and anxiety and poor self-esteem and alcohol and drug abuse, and disrupted education, mental health issues, sort of around depression and anxiety and stuff like that, but also psychosis.
Survivor 23.1

Self-concepts

Self-concept is sometimes described as a global view about oneself. However, it is not a single unitary entity, because several views of the self exist including: different concepts of selves in different domains; and different current, past and possible selves. When referring to differentiated views of the self (self-concepts), the terms working selves or identities are often used (Conway and Pleydell-Pearce, 2000; Markus and Nurius, 1986). Examples are different positions or roles, such as a mother or a teacher, which are linked to specific meanings and expectations (Stets and Burke, 2003).

The survivor narratives show that there are differences in terms of positive global self-concepts at the time of interview: this ranged from '*not knowing who I am or who I could be*' to *being content with and knowing oneself*. Survivors who felt that they had developed a global positive concept of self generally had: sought help, worked through the issues, and established supportive relationships. Although reflections on 'who we are' are not in themselves negative, several survivors report dwelling on who they *might* have been if they had not experienced sexual abuse during childhood:

> *I think that's the most frustrating thing, because I suppose my personality hadn't developed when it happened, and so I don't know what of my personality now, is it because of what happened and what I would have been anyway. […] I want to be able to pinpoint what it is, and how much it actually has affected me.*
> *Survivor 6.1*
>
> *One of the hardest things to deal with is never knowing how this shaped my personality – how has it shaped who I am? What would I have been like if it had never happened? It's like you don't really know who you are.*
> *Survivor 9.1*

Issues around sense of self are linked to memory (Nelson and Fivush, 2004). The role of memory plays a very important part in most narratives; in particular, the issue of suppressed or disassociated memory. This means that memories and linked thoughts and emotions are separated from conscious awareness to varying degrees. Fivush and Edwards (2004), studying women who had been abused in childhood, found "…*a very complex and subtle process of simultaneously remembering and not remembering, forgetting and not forgetting."* (p. 14).

Survivors describe feelings of disconnectedness or things seeming unreal and loss of memory of significant periods of time. Ways of

managing memories include avoiding thoughts and trying to convince themselves that the experience was not important or harmful as it was long ago:

> *Following the abuse [...] I buried it basically. [...] the analogy I can use is that I put it in a compartment in my head, locked it away and threw away the key, and that's where it stayed.*
> *Survivor 10.1*

> *I'd kind of – I'd not labelled, not assigned a label to it. I'd not named it or – or anything, I was aware that I had had this, um, experience [...] but I didn't kind of think about it, but I knew that that had happened but I never put a label to it.*
> *Survivor 2.1*

> *Eighteen months ago I just started really struggling with life. I was, I don't know what it was. I've always kind of got through by not even thinking about it, you know, just pretending it didn't happen.*
> *Survivor 21.1*

Some survivors reflect on the issue of memory and suggest that suppressing memories can be a coping strategy as they were at the time or indeed are still unable to cope with the memories. Others are very distressed about the loss of significant periods of time. In particular, individuals who felt that uncovering their lost memories would allow them to understand what had happened or felt that there could be no closure until they could remember most of what had happened to them seem most likely to struggle with their lives. There seems to be a feeling of discontinuity with their selves or an incomplete life history, as has been found by others (Saha *et al.*, 2011):

> *I feel as though there's a lot of stuff there that happened that I don't really know about or that – and it's not like I want to relive it or anything like that, but I want to – I want to be able to piece things together and sort of like go over it again as an adult, so that it can get properly into my memory, you know, um.*
> *Survivor 8.1*

Reflections about self-concepts were often linked to thoughts about possible selves. Survivors question if this different person might have been more successful, happier or made different life choices:

> *But I look back and had I not – I don't know what it sounds like, 'cause I know it doesn't matter to you how it sounds, but*

it always – I'm not sure that I ended up married to the person that I would have done had that not happened to me, hmm. […] … have I sold myself short?
Survivor 38.1

Research findings suggest that individuals who perceive their actual and ideal self to be different are more likely to experience negative outcomes such as feelings of anxiety and dejection (Luke and Stopa, 2009). An integrated self-concept is multidimensional and dynamic. Having a range of identities or concepts of the self promotes feelings of well-being (Stets and Burke, 2003). Some survivors managed to forge capable and confident adult selves in certain areas of their lives such as paid employment:

I think you know, as a result of abuse my self-esteem gets very low at times and I have a real conflict between – I know I'm sort of capable and confident because I wouldn't do what I do if I wasn't, but the other side of me, I really doubt myself and I think that's as a result of the abuse I experienced. So I've struggled. I really do struggle at times. I also – my adult is very intact, and say like professionally and things, I can be very strong and very competent, but it's the child in me that's not intact and that's the bit that – and if I go into that child mode, I'm a bit of a disaster.
Survivor 12.1

Fourteen of the individuals we interviewed mentioned that they were currently in paid employment. Work has always been an important part of their lives as it encourages a capable and adult confident self. There is also an element of '*giving something back'* or '*trying to make a difference*'. Most of the survivors employed were in social and health care professions such as social work, child protection, and neonatal care. Three of the survivors were in higher education and see this as an important part of their continuing journey.

Some survivors had retired and others report having been in paid employment but unable to manage as they were bullied, could not cope with flashbacks and lack of sleep, or struggled with periods of depression. Not being in paid employment can reinforce negative feelings about the self as inadequate and a limited achiever. Some of the survivors not in paid employment were seriously struggling, particularly with mental health issues. Of these, some volunteer at times and they tend to reflect on the sense of achievement that this provided within one area of their lives. Staff also highlight the difficulties survivors can encounter when seeking to hold down a paid job and emphasise that this feeds into feelings of inadequacy.

In contrast, establishing concepts of successful selves in certain areas can also come at a cost if individuals have not addressed the abuse they experienced as a child. This relates back to issues around self-evaluation and feelings of self-worth:

> *I buried everything by working, trying to be perfect, not letting anyone in. Being the perfect Christian, looking the part.*
> *Survivor 9.1*

Relationships and social support

Families

Generally, survivors tend to have disrupted or broken relationships with non-abusive members of their families in adulthood. The abuse is often perceived as a betrayal by those they loved, trusted and depended upon. This is either because the abuse was committed by a parent or a close relative or because individuals felt that parents should have protected them:

> *I mean, even I think my family, my sister told them (parents), you know, but I mean, when we were kids, they stopped him from seeing her, but they still put me in that position of the times they left me with him.*
> *Survivor 13.1*

Individuals, who had disclosed in childhood to a family member, were distressed that no action had been taken. Very few mention being unable to disclose to their parents or siblings; this they felt put a barrier between themselves and their families:

> *A lot of what I went through is down to my mother; she turned a blind eye; for me that's the most difficult thing to come to terms with. The most difficult.*
> *Survivor 29.1*

> *I told my mum what had happened to me about a year and a half ago. And I am thirty-nine years old. So yeah she … she can't really help me […] yeah it's very difficult because she can't help me, there's nothing she can do and there will always be that … thing between us.*
> *Survivor 28.1*

Disclosure to wider family members can lead to negative reactions and a break-down of relationships. The following extract is from a survivor who disclosed the abuse to her niece who she had always had a close relationship with:

She at first believed me, she went very quiet, and wanted to know the facts of what had happened and she was quite supportive, it must have been awful for you, and then she turned on me […] and they [niece and nephew] completely just cut me out of their lives, completely and utterly just cut me out of their lives and told me I was - well my nephew demonised me, vilified me, I was the bitch from hell, I'd made up all these stories, because I was jealous, I was unhappy, that it couldn't be true.
Survivor 10.1

Several survivors had not only cut themselves off emotionally but had also chosen to put a geographical distance between themselves and their families. They sometimes felt that this was necessary to contribute to their healing process:

She [mother] was on full scale denial and has been since I was eighteen, um, and she wasn't really prepared to admit it. She lived – probably still does, I don't know, I don't speak to her, but she lives in [Area] so quite a massive difference between us. […] I said 'You either need to accept that this has happened and we can work on this together and we can – and we can move forward to a new part of our relationship where we both deal with it or you can fuck off quite frankly because you're – all you're doing is causing me harm.
Survivor 2.1

As mentioned earlier, only one of the survivors had disclosed in childhood to her mother and action had been taken immediately. Their relationship at the time of the interview was very close and her mother is very supportive. However, they went through a difficult period immediately after the disclosure which indicates that support to non-abusive family members is very important:

I think it was …. It was just that…. she at the time, she was the only person apart from my other family members that knew. And so she was the only person I could talk to about it. But then, she was also the only person I could really take it out on as well because I didn't have any other outlet. You know, if I was in school I was just trying to be normal then in a way. […] And like…we are really, really close now.
Survivor 25.1

We explore support for families and significant others in the next chapter.

Partners and social networks

Survivors indicate that social support from partners and friends is very important, but in particular for those individuals who do not have any family support. Survivors report that support is provided by partners and their families, friends and other survivors. Although all survivors talk about difficulties with initiating and maintaining friendships and relationships with others, about two-thirds felt this very keenly. Difficulties with relationships seemed to be linked to a lack of trust, either in themselves and/or others. In addition, issues around being judged or stigmatised fed into concerns about making friends and finding partners. Some had actual negative experiences to disclosure whereas others expected negative reactions. Staff interviews also mention issues around loneliness, isolation and stigma. Avoiding social contacts meant a feeling of isolation which reinforced feelings of not being 'normal':

> *I think it does, because you know, I don't like really trust anybody. I don't like anybody getting too close. I've always – I've never wanted anybody to know about the past you know and you just need to keep that distance you know. As I say, last year was the first time I'd ever told anybody (friend) and it just went really pear shaped.*
> *Survivor 21.1*

> *You know, it's a terrible subject and most people really don't like talking about it at all, is what I've found. So that makes you feel worse, you know, 'cause you then can't say anything in case you're going to upset someone or make them feel uncomfortable or make them think that you're weird or something, you know. It's just a stigma thing isn't it, so.*
> *Survivor 4.1*

There is some concern that disclosing sexual abuse in childhood would 'reduce' one to a victim or an unstable person instead of a multi-faceted individual:

> *I still think sexual abuse is something that's very hidden and people don't talk about, so. I don't want to talk about things is because it's painful, but also, because I don't want to be – the abuse has shaped my life and other factors of my life. I sort of choose not to be a victim to that.*
> *Survivor 12.1*

Confusion around sexual orientation is raised by a few interviewees, which interferes with finding a supportive partner. Interviewees who thought that they may be gay are concerned that they are attracted to members of the same sex because of their abuse experience:

I mean, I was – at the time as well, I was in the process of coming out as a gay man, which I'd never been able to do really because of the, I think the way the abuse affected the image of myself and my understanding of my own self, you know. Survivor 4.1

About a third of the individuals we talked to mention a supportive partner who played a very important role in their lives:

Now I'm with my husband, you know, who's – who's so super supportive and loving, the first – first person, as I say, I can truly be vulnerable around.
Survivor 2.1

Some survivors mention finding a partner who seemed 'safe' and they described their relationships as stable and happy. However, there can be challenges as partners may find it difficult to deal with the sexual abuse and to recognise and understand that it may have a long-term impact. This can create barriers to developing mutually supportive relationships:

He just didn't get it you know. As far as he's concerned it was 25 years ago and get over it you know. […] I don't need my husband to do anything round the house or anything, I don't particularly need him there for – I don't think I need him there for emotional support. I suppose it's hard for him you know.
Survivor 21.1

Detailed analysis of the narratives suggests that there tends to be a point in the survivors lives where they were able to reflect critically on their relationships. Several survivors had decided not to enter a relationship again because they did not trust themselves/others. The following extract is from a survivor who was married three times and described all her marriages as abusive:

I have a choice that that never has to happen to me again. This is my body, this is my space. This is my private space. This is precious to me.
Survivor 35.1

Very few survivors mentioned a circle of *close* friends that did not share an abusive experience (such as other survivors) or had a good understanding of issues linked to abusive experiences (such as social workers).

Moving on

The journey to seeking help and support and moving on is very varied, highlighting the need for flexible and responsive support that is tailored to individual needs. Narratives indicate that the suffering of individuals has to reach a crisis or turning point, coupled with the realisation that they cannot carry on anymore the way they had:

> *I used to be a sort of anarchist, protesting and things like that and the only reason why I was into all of it was because it was a, a way of getting out every day, it was a way of shouting at people… [Interviewer: Channelling that anger] which is ridiculous and I didn't – I didn't realise that that's what I was doing until I shouted at a police dog and I mean I love dogs, I really, really love dogs […] And I just thought what on earth am I doing, you know? And then I sort of put two and two together.*
> *Survivor 8.1*

In order for individuals to feel able to seek support, there needs to be an acceptance that the abuse did happen and that painful emotions need to be addressed and dealt with:

> *I thought I had – I had – I had dealt with everything that was going on, I thought I had put everything to the back of my mind to the – you know, I had buried all those – all those things that happened, and just tried to live my life as normal, without having to go back.*
> *Survivor 22.1*

Asking for help and support can be very difficult and some survivors perceived that needing help meant admitting that they were a failure:

> *I was never – I never measured up, I could never cope with being the – the good pastor's wife, ummm, couldn't seek medical help because that was admission of not having enough faith.*
> *Survivor 9.1*

We explore barriers to seeking help further in the next chapter. Seeking specific help for survivors means that individuals have to disclose sexual abuse in childhood; few survivors chose anonymous disclosure and support such as Internet chat groups before being ready to disclose to others face-to-face. The reactions of others to disclosure can have a huge impact on individuals and their further journey towards healing and recovery. Individuals disclosing in

adulthood tended to disclose to partners, friends and professionals first before disclosing to other family members.

The following extract is from a survivor who disclosed childhood sexual abuse when she was 26 years old to an elder in her church. The negative experience meant that she did not actively seek help again until much later in live:

> *I went to this elder, um, he just asked a few questions about my childhood and um, a little bit of it came up and there was a prayer [laughs] for um, basically for forgiveness on my part, um, casting out of a spirit of lust and something else and um, you know, none of it seemed to fit, none of it felt right.*
> *Survivor 9.1*

Some survivors mention that the initial contact with counsellors and support groups was a detrimental experience. These negative experiences are more likely to happen with generic rather than specialist services. This delayed individuals accessing further help and support which often meant a worsening of their state with bouts of depression, low self-esteem, feelings of isolation, shame and worthlessness. Staff emphasise that early intervention can help to prevent the habituation of negative coping mechanisms and generally lead to better long-term outcomes.

Narrative by others who had positive and supportive reactions to disclosure tended to access support such as one-to-one counselling and support groups in a more timely way. As individuals at this point were very distressed, the importance of others in signposting individuals towards agencies that can provide help cannot be underestimated and is explored further in the next chapter:

> *I went to my GP, who was brilliant, and he gave me some local counselling organisation numbers […] I was so bad at that point, that I would start phoning them at 6 o'clock in the morning. I knew they didn't open until 10, but I just had to be the first one on the line and they were brilliant and it wasn't too long before I was given a series of 12 sessions with a counsellor, specifically to deal with the abuse, and that was brilliant.*
> *Survivor 10.1*

So I'm very fortunate in that I have a couple of good friends that were also counsellors – well one is a social worker who's worked with abused children and two other friends that are counsellors, and between them they found out about (organisation) and got me in touch with (organisation).
Survivor 38.1

All individuals accessed support over various times in their lives. Most accessed support groups and counselling (general and specific) repeatedly at different points in their lives. Survivors' narratives suggest that a continuous means of support or access to support in some form is essential. The following extract is from a survivor who pays for counselling sessions when she feels in need of some support:

Yeah it's been helpful. It's not something – I just see that as part of looking after myself. You know. I go in and I – it's helpful. […] it's just other things that have happened, which could be related (to the abuse), but just sort of life events really and I just get overly stressed. What I would find really helpful, would be a group […] something attached to me that's really private and I'd need it to be really, really safe and private and I think I could do well.
Survivor 12.1

Some survivors accessed support but felt unable to stay with the counselling or support group and to open up and address the issues. The following extract is from a survivor who accessed sexual abuse specific counselling but found it impossible to open up. It took her almost sixteen years to go back and seek help:

So and I went for counselling there. And it did help me a lot but at the same time I was still sort of holding back as well. I thought this is getting too far now where I need you know. […]. It was a sign of weakness because I knew I had to be strong and I am going to show those sods I can be strong. And I built up such a wall you know, with me, so nobody could get in.
Survivor 20.1

Some survivors believe that they had not been ready at the time to deal with the abuse and the emotions; they highlight the importance of well-trained and experienced professionals in this context. There sometimes is a danger that blame is put on the survivor who is not 'progressing' and already struggling with feelings of guilt, shame and self-blame:

And they're (survivors) just seen as the ones who haven't quite got it right or if they don't respond well to – well then they're – they're not any good, are they, and they (professionals) don't think, well maybe perhaps our therapy isn't suitable, we're not helping them.
Survivor 5.1

Most individuals did not look for specific counselling for survivors of childhood sexual abuse to begin with; this was partly because they were not aware that such a provision existed or that at the time they were not ready to deal with the sexual abuse and were looking for more general support. Individuals report searching for information and support on the internet and/or in books and then looking for support groups or one-to-one counselling. One of the survivors had never accessed formal support: she recognised that she had been sexually abused in her late teens and eventually decided to make a complete break. She went to a developing country twice as a volunteer and the experiences there (such as abject poverty) helped her put her own childhood experiences into perspective. She has a very supportive partner and a close group of friends. She also works in a caring and supportive environment and is very dedicated to her work.

The narratives suggest that for individuals to start healing or moving towards recovery they need to:

- be ready to accept that the abuse happened and that they need help;

    You don't know that you need help or that there's underlying problems until you realise it yourself. There is no point in people telling you.
    Survivor 19.1

- deal with painful emotions and feelings of loss and sadness;
- place responsibility where it belongs and work through feelings of guilt and shame;

    And I'm forty-five years old, to realise that you're the victim of this, that you were innocent in that, does – it does release a huge amount of pressure off you. I don't have the knots in my stomach anymore.
    Survivor 22.1

- work through difficulties and develop coping strategies;

    I still get dreams of that in – in my dreams, if – if he's in it, um, I'm confronting him, you know, and I'm shouting at him and you know, it – it – I'm in control, whereas before, you

know, this dream and the flashbacks, he was always in control, you know, so (counselling organisation) has helped that way.
Survivor 13.1

- build support networks;

  I've got what I need, um, you know, I've got things, like my group that is going to be a lifetime thing, um, whether it's every week or every couple of weeks I go, um, you know, I've got a network of friends that are really supportive that you can say anything to and they understand.
  Survivor 17.1

- accept themselves as they are now and develop a sense of self and self-worth.

  You know, figuring out who you are and so it's almost like you're ten years behind everyone else, um, in sort of thought processes and decision making about where you want your life to go.
  Survivor 8.1

Some individuals also talk about the need to find a sense of closure. This can mean taking the abuser to court and trying to secure a conviction, confronting the abuser or forgiving the abuser. Survivors who talk about forgiving the abuser draw their strength from faith.

Survivors who talked about themselves in a positive manner and reflected on their ability to cope with their experience of childhood abuse had developed a range of coping strategies and support mechanisms. Research has shown that active approach-oriented coping strategies such as engaging with others, cognitive restructuring and expressing emotions facilitate recovery. In contrast, avoidance-oriented coping strategies such as social withdrawal and denying thoughts and feelings hinder recovery (Frazier, Tashiro, Berman *et al*., 2005; Rosenthal, Hall, Palm *et al*., 2005; Littleton and Breitkopf, 2006).

Coping strategies described by adult survivors as positive include:

- *Managing thoughts and emotions:*
  o Developing different thought patterns.
  o Using techniques to cope with negative thoughts.
  o Focusing on positive aspects in daily life.
  o Using visualisation.
  o Keeping a reflective diary.
- *Managing self-defeating patterns of behaviour:*
  o Tackling addictions.
  o Addressing self-harm.

- o Reflecting on and addressing abusive relationship patterns.
- *Managing memories:*
- o Accepting memories.
- o Stopping dwelling on memories of the past and looking towards the future.
- o Integrating childhood memories into the adult self.

- *Restoring or re-defining a sense of self:*
- o Accessing formal and informal support systems such as one-to-one counselling and support groups (on-line or face-to-face) and Community Mental Health Teams when needed.
- o Learning new skills such as educational competencies or photography.
- o Developing capable and fulfilled selves (for example, paid employment, children).

- *Giving something back:*
- o Volunteering and fundraising for charities.
- o Awareness raising.

- *Faith:*
- o Strength through faith or spiritual awareness.
- o Being a member of a religious community.

- *Building support networks:*
- o Friends, partners and other survivors.

Narratives of individuals who feel that they have moved on tend to include reflective elements - *'looking back'* - indicating a more in-depth understanding of their thoughts, feelings and behaviours at different times in their lives. This greater self-awareness tends to be reflected in an understanding that they are not to blame for what happened:

> *Looking back I think all through my adult life, ever since my brother did that, I've had – I've definitely had bouts of depression and I've never been treated before, I've never been diagnosed before. But knowing what I know now and looking back, hmm, realising how low my self-esteem was, how much I hated myself, how worthless I thought I was, I realise that it has affected my whole adult life, I just didn't remember why, hmm.*
> *Survivor 38.2*

Survivors feeling that they have moved on in their journey to healing talk about *knowing* and *accepting who they are*, *enjoying life*, *looking forward* and *seeing opportunities*:

I think I certainly have – all you can do is the best with the hand that you are dealt, you can't change what happened in the past, but what you can do with the future actually that's what makes a difference and, um, for me, I have to […] I feel like I have to – I have to try and make a difference to people.
Survivor 2.1

I have still got too much living to do yet. And I still need to catch up on a life that I should have had but never did. But no regrets, no regrets. But now I am actually living. I feel free for the first time in my life. You know because before, er … I was ... because I didn't know who I was … and I was living and I didn't know who I was. […] I don't feel the same person. […] I know who I am now.
Survivor 20.1

Summary

In summary, the narrative approach highlighted the differences and communalities in personal journeys of survivors of childhood sexual abuse. Reactions from others at disclose, either in childhood or in adulthood, play a central role in how survivors make sense of their experiences and influence individuals' approaches to seeking support and help. The sense of self changes over time and is linked to emotional and thought patterns about oneself. These perceptions about oneself are linked to behaviour that may be self-destructive. Individuals need timely and compassionate support from others, such as friends, family and/or professionals, to move towards healing and recovery.

Chapter 4 Supporting adult survivors of child sexual abuse

Introduction

This chapter considers service provision to support adult survivors of child sexual abuse; it includes extracts from the narrative accounts of adult survivors, as well as from the first-hand accounts of staff working in our two study sites and staff employed in national third sector organisations.   We report on the key service delivery challenges, highlight the main gaps in current service provision and explore the characteristics of the relationships between adult survivors and health and social care professionals. In doing so, we also identify unmet needs for help amongst adult survivors.

Our analysis of the data set is on-going; further findings, including those that address support from the police and survivor experiences of the criminal justice system, will be presented in future collaborative papers arising from this work. As noted, members of the Project Reference Group will be actively involved in writing these papers for publication.

Service delivery challenges

The main service delivery challenges, as identified by adult survivors and staff, are described below. They include:

- Supporting a difficult to reach group.
- Recruiting and retaining *specialist* staff and volunteer support workers.
- Funding and resource issues.
- Ensuring services are sufficiently flexible and responsive to individual survivor needs.
- Working jointly to support adult survivors and their families.
- Lack of awareness amongst key stakeholder groups.

Whilst some of these challenges relate specifically to supporting adult survivors of child sexual abuse, others are more general and applicable to other vulnerable individuals who access services.

Supporting a difficult to reach group

Staff across the statutory and third sectors describe the reluctance of survivors to seek help and access services *in general* and, *in particular*, the reluctance of male survivors, older survivors (aged 55 years and over), survivors from Black and Minority Ethnic groups

and survivors from some faith groups (especially Jehovah Witness and Muslim faiths):

> *It is such a shame issue but it has always been difficult for survivors to contact us, so there is nervousness and a difficulty of expressing themselves on the phone, dealing with answer machines, coming for appointments…. I think there has been a big reluctance of males to face abuse, well to be able to talk about; it's the whole macho thing. I think it is much more difficult for a male client to come forward.*
> *Staff 62.6*

> *The older generation I think it's more difficult if anything to be honest because they've not always moved on….they're very much still back, back there, years ago even though, you know, these sort of things are really out there.*
> *Staff 35.6*

> *We are trying to reach out to communities that find it harder to come forward so BME community groups for example….we are trying to find ways to reach out to other people so that it can feel safe enough to come here… Jehovah's Witnesses as well consistently talk of the shame within the family and the community, of being ostracized by the community if it comes out.*
> *Staff 6.6*

The importance of being sensitive to cultural and religious beliefs is recognised, as well as working closely alongside community, faith and other specialist groups. Work is underway in one of our study sites to strengthen collaborative relationships between a survivor organisation, the police force and the Black Association of Women Step Out, which supports women and children from BME groups who are made homeless because of actual or threatened abuse.

The limited availability of male support workers, which is highlighted by staff as a major gap in service provision, heightens the challenges associated with encouraging male survivors to come forward and seek help. Staff working in national organisations confirm this as a UK-wide problem that serves as a barrier to the development of specialist male services; they identify the need for gender appropriate services that actively seek to redress stereotypes relating to the transmission of inter-personal violence by males on females as well as challenge stereotypes relating to traditional masculine traits. The male survivors who we spoke to confirm these prevailing stereotypes as a barrier to accessing support and highlight the limited availability of specialist male services:

You think that you're the only male who ever goes through this….You pick holes in who you are and your whole identity, your appearance, sexuality, everything…...There needs to be more support for men… Men need help too – we are human beings at the end of the day. There are so many men out there that need support and come to the point where they have to ask for help and then are told that there's nothing for men out there.
Survivor 30.1

There is some concern amongst staff that strategies seeking to address violence against women, whilst important, have served to marginalise male survivors and detract attention from addressing key issues relating to males accessing services. Our findings concur with those reported by the Survivors Trust (2010) on the dearth of male services, particularly for young men aged 16 to 18 years old.

Fear of not being believed and fear of rejection are further barriers to seeking help as the extracts from the survivor accounts illustrate:

Being believed, now that's a big issue. I'm not lying people, I'm not lying… I needed support but I got nothing from these so called caring professions… They don't appreciate how hard it is to ask for help in the first place and how low, how very, very low you are.
Survivor 29.1

It's tough enough to ask for help, you know, I think to go to a GP and just say you know, I'm ticking all of these boxes, I'm having you know, I really have flashbacks or I'm experiencing this or I'm experiencing that. You know, it takes a lot of courage to be able to go into a – in to see a GP, who you know might not be responsive. I had a fear – I had a fear that my GP would say, you know, I think you're making it up, you know, and sling me out the door, and I wouldn't be surprised if that could happen to people.
Survivor 8.1

As noted in the previous chapter, being believed is particularly important for survivors as they seek to make sense of and cope with events that happened in their childhood. Survivors and staff allude to the stigma associated with sexual abuse and the shame that is often felt, as well as the negative, enduring stereotypes associated with accessing support from counselling services and community mental health teams:

The shame….I moved 200 miles because I just wanted to be away and I didn't want anybody to know anything about me or where I'd come from or anything you know.
Survivor 22.1

…. it is such a taboo, even now we are all so enlightened in the twenty first century…. I think there is still a bit of a stigma to counselling it is, Oh, gosh you know it is sort of middle class and Englishy, I don't know.
Staff 62.6

They go I am not mental. And I think that is fair comment. For some of them, a mental health line will be appropriate, but others would say yeah I've got issues, I've got problems, but I am not mental.
Staff 7.6

The importance of ensuring that services are discrete yet accessible, confidential and safe is highlighted by survivors and the challenges this presents are acknowledged:

Instead of catering to everyone's fear, to kind of like not have a big neon sign on there going like Survivors United or whatever, but you know, give it a nice name, but we know what it is and we can go in there and you know, and just do the thing.
Survivor 15.1

So, it's a difficult thing, because I mean how do you provide – how do you make provision for someone who's problem is so secret, that they're not going to just you know, if you put a stall up at the town fair or something like that, you're not really going to get any takers.
Survivor 23.1

The recruitment and retention of *specialist* staff and volunteers

Survivors and staff highlight the importance of *specialist* help and support, in particular, specialist counselling delivered by individuals who work *only* in the sexual abuse field:

I'd like some more counselling that's specific for sexual abuse…. It's really difficult in this situation to actually ask anybody for help you know. You can't sort of walk into someone you don't know and say – it's not the first thing you could bring up with anybody you know, and it's hard then if

you go for general counselling. I think it does need a counsellor who knows specifically about sexual abuse you know, because otherwise you probably spend so much time trying to get round to the crux of the matter.
Survivor 21.1

I am so used to advising people not to go to generalist counsellors. I would highly recommend that it is a specialist counsellor because, I hate to say it, but there are just as many charlatans in the counselling business as there are in any other. And they will pretend to be able to help whilst having no in depth knowledge about the actual subject and…I mean, I have had run ins with a couple of counsellors who have no knowledge of the criminal justice system, had no awareness that they could completely and utterly negate a trial… a trial would have to finish and that person that they are supposedly helping is then…huge damage.
Staff 15.6

Appreciation and gratitude for the support provided by *specialist* organisations is evident in the survivor accounts; the expertise, sensitivity and responsiveness of staff and volunteers engaged in these organisations is recognised. In contrast, survivors and staff suggest that accessing *generic* support services may sometimes further intensify survivor feelings of guilt, shame and stigma; the lack of specialist knowledge means that responses can be inappropriate and insensitive.

The recruitment and retention of experienced, *specialist* counselling staff and volunteer support workers is a key service delivery challenge, affecting the capacity of organisations to offer timely, specialist support, both to survivors who have recently disclosed for the first time about events that happened in their childhood and those with longer-term support needs:

The waiting list at the moment I think is about forty plus. It has been, I am disgusted to have to say it but it has been up to two years. It depends on the intake of counsellors. That's the limiting factor. And because we are a country area, there aren't that many people available; there aren't that many counsellors available.
Staff 59.6

Third sector organisations in our two study sites rely heavily on experienced volunteers to deliver services; however, it is difficult to attract people to work in this sensitive, challenging field and

volunteer numbers are declining because of the imperative to find paid employment in times of recession:

> *People had to get paid work in this, you know, constrained financial times, yeah they had to get paid work and had less time for volunteering. So our volunteer base suddenly dropped back considerably.*
> *Staff 47.6*

> *I find that on the helpline and by email, people tend to give a lot more explicit information and I think, for example, they might run through word for word exactly what happened when they were raped and how it made them feel…. So I think that, particularly for the volunteers who have never done this sort of work before, I think that kind of explicit information can be quite hard for them to hear…. it has obviously attracted volunteers who have come from a Christian background and they have found that kind of information really difficult to deal with.*
> *Staff 6.6*

Difficulties in ensuring continuity of support worker are highlighted by staff; survivors suggest this is essential to building relationships of trust that facilitate the disclosure of highly sensitive, intimate information.

Funding and resource issues

Funding is a major theme running through the survivor and staff accounts and the need to address funding deficits is a key message offered at close of most staff interviews; this is not surprising given that the fieldwork was completed during a time of recession and public spending cuts. Funding deficits have a significant, detrimental affect both on the *availability* of services and the ways in which services are *delivered,* as well as the potential to build service capacity:

> *Well money is a huge thing actually, there isn't the funding, there isn't finance and there isn't adequate support. People just aren't looking at the bigger picture.*
> *Staff Joint Interview 36.6& 61.6*

> *I think that's the other difficulty for us really is that if you say to somebody yes there's this service, but its only open on a Thursday and its Tuesday night and you know, things are not sort of out there.*
> *Staff 7.6*

> *….they might feel better they've given her the leaflet to read. Yeah. Number on it to ring. Ring the number. Answer phone. Okay dead end. Put it in the bin. Not going anywhere with that. And then you're back on your own again.*
> *Survivor 35.1*

Staff report that the demand for support exceeds the capacity to respond in a timely way to vulnerable individuals who are often experiencing acute distress. In particular specialist counselling services report waiting lists of up to two years following an initial referral for help:

> *Currently we have about 60 people on the waiting list for (area)… there's just a total inequality between the resourcing that we have and the demand for the service.*
> *Staff 11.6*

Service provision is compromised; for example, the number of counselling sessions offered to survivors is often restricted (usually up to a maximum of twelve sessions). This provokes strong reactions from survivors, who acknowledge the vital support they have received:

> *I think if sex offenders are in prison, they might well get counselling quite easily, you know and so it's really not fair that that isn't the same for survivors at any – you know, at any point when it becomes necessary.*
> *Survivor 4.1*

> *I am damned angry that I waited thirty years of my life. And that I have had no job that I could hold down. No relationship that I could hold down. I have no children. I've been single and celibate for 17 years and for a 39 year old man, that's the best years of your life, right there. All of that waiting to sit in a room and talk to someone. So I would to ask the Welsh Government why? Not them specifically, but the government generally. Why? Why have I lived like this for 30 years for want of professional help?*
> *Survivor 28.1*

> *We're alive. We are human beings. We didn't ask for this to be done to us. You know, we were the victims as children. We've survived it. Aren't we worth it?*
> *Survivor 35.1*

It is demoralising for staff and volunteers:

I can't put in words, except I am angry and disgusted and I am appalled at the short-sightedness of it….it is a message to people who have been abused; it is Society does not think they are worth it. That is great on top of what they have gone through. It's absolutely stinking horrible, so yeah, nobody thinks I am worth it. And that is a horrible message to put to somebody.
Staff 62.6

Staff report that managing waiting lists can be problematic as some survivors, having had the courage to come forward and seek help, get very angry about the situation. The cost of private counselling can be prohibitive.

On-going support for survivors following their maximum allocation of counselling sessions is identified as a major gap in current service provision both by survivors and staff; this includes emotional (as opposed to therapeutic) support, which might be provided through facilitated peer support groups, and practical and advocacy support that might be offered by key workers and advocacy services. Some survivors suggest that opportunities to meet up with other survivors on an informal basis, not necessarily to talk about the abuse and its long-term effects, might help them to address feelings of isolation and loneliness and overcome their difficulties in establishing relationships with others. Importantly, access to emotional, practical and advocacy support can potentially help to maintain positive outcomes achieved through therapeutic interventions and, in the longer term, prevent individuals from relapsing into negative thought processes, patterns of behaviour and coping strategies:

RES1: So support is a role that we are really, we really think is undervalued actually…

RES2: Practical support and dealing with those things that are outside of their counselling and contacts are needed so somebody who has perhaps has got chaos in their life at the moment and is needing to work through that and have support workers there to help with the things that can't be dealt with in counselling; so we need more volunteers to do that sort of work.

RES1: And really very very long term support as well, there is no money available for that….For example there was a lady asked if someone could help her to go shopping, well it is not, kind of, in our remit but there is nowhere where we can refer her to is there…

RES2: And have help with skills of forming relationships because I often say, and this might sound daft, but if people had friends and people around them then that is half

> *the battle isn't it of not feeling alone and not becoming reliant upon one organization.*
> *Staff Joint Interview 10.6 & 55.6*

Staff report that it is difficult to secure funding for this type of work.

Based on their first-hand experiences staff identified counselling as a beneficial, cost effective intervention; statutory and third sector staff alike express concerns about the limited resources for specialist counselling provision and they highlight the implications for primary and secondary health care services. In particular, for GPs and Accident and Emergency Units coming in to contact with survivors who present with mental health problems, substance misuse problems and/or self-harm injuries:

> *…if we're not able to pick them up right away, people sort of tend to just relapse into whatever it was they were already using to try and cope, and obviously, that I think has implications for the health service, people are back to their GPs, they're on long term medication, they are at accident and emergency with self-harming behaviours. They're using alcohol, they're using drugs, and they're using whatever… There's no way you'd say to somebody who was having open heart surgery, well we can only open you up, we can't actually go in and sort your heart out or close you up afterwards you know, but that's actually what we're saying with some of these people. It's just nonsense really. It's totally inappropriate and unethical and dangerous.*
> *Staff 11.6*

Awareness raising and future service development activities are compromised, including the development of:

- 24 hour on-line and telephone counselling services.
- Comprehensive information strategies.
- Specialist support for:
  o Transgender survivors.
  o Survivors who are serving prison sentences (including those that disclose *prior to* their prison sentence and those that disclose *whilst in* prison).
  o Perpetrators of abuse who are *themselves* survivors of child sexual abuse.
  o Survivors who are experiencing relationship and/or sexual difficulties.
  o Making applications for criminal injuries compensation, as well as more general legal advice.
  o Families and significant others.

These comprise key gaps in current service provision.

Presently, the main source of support for families is their GP (usually when seeking help for depression and anxiety related disorders) or by default from survivor organisations, though family support may not necessarily be part of their official remit. Staff report that the limited support that is available for families focuses on helping spouses, partners and children to understand the behaviours and emotions of the *survivor* and the effects of the abuse on the *survivor's* life; whilst this is very important it neglects *their* emotional reactions and potential strategies for coping. The effects on family relationships were described in the previous chapter. Staff suggest that future service delivery models might be informed by the work of organisations who adopt a *systems approach*, including those that support individuals experiencing domestic abuse within the family and those supporting families where individuals misuse substances. The reluctance (described by some staff) of spouses and partners to be seen as vulnerable can detract from them seeking help and presents a challenge for professionals in seeking to support them.

The disproportionate amount of staff time devoted to securing future funding for third sector services and completing monitoring returns on existing short-term grants is highlighted as a significant distraction from delivering frontline support:

> *We've also had grants from the WCVA small grants fund and from the social risk, but all of that is stop start funding….by the time you get into a project and work for a year you're exiting, so you've got to stop working with clients because you're not going to be able to afford to complete and it takes a lot of work just applying for it and the monitoring that's required for the amount of money that you're given is ridiculous.. I do understand people have to know that – you know, there has to be monitoring, but I think some of that – the levels of monitoring and the things that are asked for are very difficult to comply with, not just because of what they want, but because what they're asking for doesn't necessarily fit the sort of service we deliver, where sort of qualitative evaluation is much more relevant.*
> *Staff 11.6*
>
> *We have to quantify or do a qualitative analysis of the demand for (organization and service). And we had to go into outcomes and all this kind of stuff. And I just said we have a waiting list. What more do you want? Yeah but is there a need for (organization), I mean, is there a need out there? Okay let me*

*try it again and I will speak slowly – we have a waiting list!
That shows the demand. What's your problem with that?
Survivor 59.6*

The short-term nature of funding compromises the long-term sustainability of services, making it difficult for those working at a strategic level to formulate service delivery plans for flexible, responsive support.

Staff report that present financial constraints have led to the development of a culture of competition and, in some instances conflict, rather than collaboration amongst third sector organisations, some of whom are becoming increasingly self-protective and insular. This, in turn, has a detrimental impact on the building of collaborative relationships and partnership working, as well as efforts to promote greater awareness of sexual violence. It hinders visionary, joined-up thinking, the development of more effective models of service delivery and, ultimately, change. Whilst the importance of working together is recognised by third sector organisations in principle this is sometimes difficult to achieve in practice:

> *RES1: I tell you where we have had difficulties which are not surprising considering that we are all after the same money is with other third sector organizations… Charities want to work together but fear working together because you might get the money and we won't… And that is really sad… it is a shame that you don't feel free in some ways to work more closely with other voluntary organisations but it is just the way it is I guess.
> RES2: You know, we need to stand together not be separate.
> Staff Joint Interview 10.6 & 55.6*

> *Protectionism isn't helpful and organisations need to remember who they are trying to help – the survivor. We need to learn to support each other in the work we undertake and to build relationships."
> Staff 30.6*

> *…. they are protective and, you know, 'my victims' and sometimes it can be used as barriers, if you like, with some organisations for multi-agency working.
> Staff 31.6*

There is a reluctance to invest in building partnerships with organisations whose life-span *might* be limited because of ad hoc, short-term funding. The Scottish model of funding for sexual

violence organisations is highlighted as an example of good practice and discussed in chapter five.

Funding limitations not only affect the *availability* of services to support survivors but also the *nature* and *delivery* of these services; ensuring that services are sufficiently flexible and responsive to individual needs comprises a key challenge for provider organisations across the statutory and third sectors and is considered below.

Ensuring services are sufficiently flexible and responsive to individual survivor needs

Health and social care policy recognises the importance of flexible, responsive services that are delivered in timely way (WAG, 2007; 2011). Survivor and staff accounts of service provision suggest that policy ideals are not always translated into practice:

> *We have to think outside the box…but how?*
> *Staff Joint Interview 36.6 & 61.6*

In particular, the nature of support available is not always tailored to survivors' individual needs and personal preferences and the timing and location of services are often experienced as inflexible. For example, specialist counselling services, although highly valued by survivors and frequently described as *life changing*, are experienced as inflexible; some find it difficult to travel, what are often considerable distances to attend counselling sessions, and/or find the scheduling of appointments problematic given their other commitments:

> *And to be honest with you the travelling up there was probably the worst part of it…. I was always sitting in the back of the car. Like puking.… and then coming out there was half hour drive thinking about it all. So that used to drain me a bit.*
> *Survivor 25.1*

> *We want the client to turn up fortnightly, on a Wednesday or a Tuesday or whatever, and so that is – and as I say, you know, if there's problems with transport or child minding or anything like that, then that's something they've really got to take into consideration, before they actually refer to us.*
> *Staff 47.6*

Travelling time after a counselling session, when emotions are raw, is especially problematic. Limited or no access to private transport compounds the situation; the potential of on-line or telephone

counselling is highlighted by survivors and staff in this context. Whilst for some individuals hourly counselling sessions scheduled for every two weeks over a six month period are helpful, for others, particularly those living alone with limited informal support networks and those who have chosen not to disclose to their family, the scheduling of these appointments is problematic; they would prefer weekly two-hour sessions. The need for greater flexibility to work at the survivor's pace is highlighted. One survivor describes how she feels restricted by the scheduling of her counselling sessions, which in turn influences the information she discloses to her counsellor:

> *You're frightened of disclosing something too deep near the end of a one hour session because you know you have to deal with it on your own when you leave. You become very selective about what you talk about in those sessions. Once a week for two hours would be much better for me; they need to realise that we are all different – for some that hour may suit them but not all of us… Basically these people need to be more flexible; they need to treat each person as their own person and realise that they are in their own place; it's the same with hospitals.*
> *Survivor 29.1*

The potential usefulness of peer support in between counselling sessions is highlighted by some survivors and is recognised by staff.

Survivors are mindful of the difficult financial climate in which service organizations are operating, however, they feel that services are delivered at the providers' convenience rather than flexibly in ways that accommodate their needs and personal preferences:

> *I know there are limited resources but one size does not fit all.*
> *Survivor 9.1*

The Gender Equality Duty (2007) requires that organisations take action to bring about gender equality and create effective service provision for all, so that everyone can access services that meet their needs. However, the limited availability of male counsellors means that it is difficult to achieve this in practice and to deliver gender sensitive counselling services that accommodate survivors' personal preferences.

Similarly, the limited availability of Welsh language counsellors makes it difficult to accommodate language preference. The importance of respecting language preference and offering counselling and support via the medium of Welsh is highlighted by some survivors, who spoke about the difficulties of expressing

feelings and emotions in the English language. However, this is not always recognised by staff, who view language preference as secondary to the skills and sensitivity of the counsellor:

> *And to very very brutally honest I don't think that many survivors would have that as top of their… It would be on their agenda…. it would not be the top. The top would be, 'what do I have to say and disclose to these people, I am embarrassed' etc. etc. 'What help can they give me because I don't know what help I am looking for'. 'I just want to be able to deal with all this shit that is going wrong'.*
> *Staff 15.6*

> *Well I'm certainly not a Welsh speaker and I don't think that any other members of staff are either to be honest. We've never come across an issue where we've had Welsh speakers who couldn't speak English here.*
> *Staff 35.6*

> *I do feel that it is a relationship that develops between the counsellor and the client. That does the healing…. So maybe language isn't such a barrier, if the person can express themselves and can feel that the counsellor is empathizing with them truly.*
> *Staff 62.6*

Some survivors report communicating in the English language when their preference is to communicate in Welsh; as vulnerable individuals they believe this expedites their access to counselling and other support services. Clearly, this can make it difficult for professionals to gauge survivors' language preference:

> *Although I would question, in a way, that if you are not doing it in English whether, because people are in a position where they are vulnerable, whether they might just have agreed to that just because they want the service anyway… we could do more.*
> *Staff Joint Interview 10.6 & 55.6*

Where Welsh language counselling provision is available it often means survivors travelling long distances to see a counsellor and/or making compromises in relation to speaking with a male or female counsellor; the commitment to delivering services based on individual need and choice is not always translated into practice. Staff highlight the potential usefulness of Welsh medium training for counsellors in order to meet their responsibilities under the Welsh Language Act and respond to first language choice:

If they want us to be bilingual, then help us to be bilingual.
Staff Joint Interview 36.6 & 61.6

Welsh is my first language. And there are sort of two or three points I would like to make. First one is that there is no counselling course to my knowledge in Welsh. There is no bolt on add on time given of any of the course … to do any of the training for the diploma in Welsh and it is important because the terminology needs to be … got worked out and the phrasing of questions and things, because doing a literal translation doesn't work. That's the first thing. So the professionals need to be trained. Secondly, the Welsh community in general are a little bit slower coming forward…it's a taboo subject still very much so. And if we were able to advertise the fact that we have a specific group of counsellors who specifically counsel in Welsh then I think that would be a big plus… we're going back to childhood. And it is going to be spontaneous and memory coming back. It ought to be in the language that they were thinking at that point.
Staff 59.6

National UK support lines are able, on request, to provide information to survivors in a wide range of European languages, though not in Welsh:

….we have got a number of our support team who are fluent in at least one other language. Welsh not being one I'm afraid. But we have probably got about 8 different languages and then English.
Staff 4.6

Intermediaries, for example, signers are available to most organisations to help support those with hearing difficulties or other communication needs.

Problems relating to the nature and type of support and its responsiveness to individual need are raised by survivors and staff; in particular, the suitability and appropriateness of peer group support:

Balance. It's about - they say I don't want to go and sit in a room and talk about it thanks. No, I don't want to share my experience. And for a lot of people they don't. A lot of people get something out of it and others don't. It's very individual I think how that person that will deal with it.
Staff 56.6

In both our study sites, membership and attendance at peer support groups is offered to survivors whilst they wait for one-to-one counselling; staff see this as an important stop-gap measure. Whilst some survivors are keen to meet up with others to offer peer support and learn from their experiences, in particular, to share strategies for addressing feelings of guilt, self-blame and low self-esteem, others are unable to contemplate support delivered in group settings. Concerns about breaching confidentiality can negate the potential benefits of group support.

Staff recognise the importance of learning from survivors, in particular, from their experiences of service provision, and using this evidence to underpin future commissioning and service development activities; recent work undertaken by the Survivors Trust (2010) concurs with this and outlines a set of sector specific outcomes, which are explored in the discussion section. It is important to recognise that obtaining service user feedback about what works well and where there is scope for services to improve is challenging for organisations, particularly for those who operate helpline services, as callers may call anonymously and may only call on one occasion.

Working jointly to support survivors and their families

Successive health and social care policies have underscored the importance of effective joint working to support vulnerable individuals and their families (WAG, 2007 a&b; WAG, 2010). Whilst staff fully endorse the principle of working in partnership and ensuring that clients lie at the heart of partnership arrangements this can be difficult to achieve in practice:

> *I'm fairly disconnected from a lot of other services.*
> *Staff 46.6*

> *We do realise that we're a bit standalone and we do really need to work more with other organisations and we're hoping to be involved in an initiative in (area).*
> *Staff 47.6*

> *In some areas you get really good relationships and others, you spoke of this earlier, they are protective and, you know, 'my victims'… For example, for ourselves we work with multi-agency centres, where obviously we support male victims of sexual and domestic violence. And (organization), in some areas they would absolutely refuse and we really really struggle and we may all be in the same building but no way*

are we partnership working; they would have a locked and bolted door and nobody is to come in or out of there…. So I think that that is, I guess, it is about ground level stuff isn't it.
Staff 31.6

Survivor observations relating to the lack of effective coordination, signposting and referral systems between service providers confirm this:

You know, I've found that whole system inaccessible really…I suppose he (GP) must have referred me to the community psychiatric health team, I mean, I thought you just asked your doctor to see a counsellor and they book you with a counsellor, but apparently that's not how it works, anyway…. when I heard I was going for a psychiatric assessment I thought, you know, what I want is some counselling, I don't need you to tell me that I need some antidepressants or something, you know, so, hmm…. I asked for another appointment, but it hasn't come yet, so. I even asked the doctor when I went – I went to the surgery and spoke to him in person and he said "I'll ask to have – to get another appointment for you" but it hasn't arrived and I don't know how long you're supposed to wait really, but it's been months, months and months now [laughs], you know, at least three months now.
Survivor 4.1

Their narratives highlight the fragmented, piecemeal responses to supporting individuals who are seeking help to cope with the trauma of child sexual abuse; in particular the lack of a coordinated approach to dealing with drug and alcohol dependency and eating disorders. Our findings concur with recent work completed by the Survivors Trust (2010) that suggests that the ways in which services are organised and delivered further reinforce the sense of fragmentation and detachment experienced by survivors.

Both strategic and operational staff report limited understanding of the roles and responsibilities of professionals working across the statutory and third sectors in general and, in particular, confusion about the remit of professionals working with people affected by *domestic* violence and professionals working with people affected by *sexual* violence.   This can undermine staff confidence in the appropriateness of their referrals to other organisations and confidence about the quality of service(s) these organisations are able to deliver.   It can also compromise decision-making.   Staff working in specialist sexual violence organisations feel strongly that the distinction between *domestic* and *sexual* violence should be

made clearer and be more widely recognised both at strategic and operational levels; they highlight confusion at strategic level, where it is wrongly assumed that monies allocated to support people affected by *domestic* violence will also be available to organisations supporting those affected by *sexual* violence.

Allied to this, third sector staff report on what they perceive to be an increasing number of inappropriate referrals from statutory sector organisations, in particular, from Community Mental Health Teams; this is viewed by some staff as an attempt by statutory organisations to avoid incurring costs, as these referrals are not supported by Service Level Agreements, and it can sometimes lead to tenuous and difficult working relationships:

> *I know a service in my (area) where a lot of the women who were referred by mental health services are the most chaotic, the most angry and the most difficult borderline personality cases you can find. And mental health services cannot deal with them so they have actually passed them on to the voluntary sector. Especially if they get a disclosure of abuse… Oh we still shouldn't be dealing with that, we deal with Schizophrenics or we deal with other stuff. We don't deal with sexual abuse. And that's quite a prevalent attitude. And that's where we need to train.*
> *Staff 51.6*

> *Mental Health teams they sort of tend to shunt if anybody does disclose, they shunt them towards [organisation] without actually offering any support themselves because their sort of attitude is, oh, yeah, if you have been sexually abused and you are behaving irrationally its perfectly normal because… because of the sexual abuse. You are not actually mentally ill therefore we cannot use our funding for you.*
> *Staff 62.6*

> *Sometimes it feels a bit like a tick in a box, you know, I don't know how good the assessments are or the ways of referring people on because we do get quite a few inappropriate referrals, don't we?...... if someone mentions sexual violence then it is a chance to kind of push them on.*
> *Staff Joint Interview 10.6 & 55.6*

The increasing number of inappropriate referrals *may* signal that CMHT members do not feel adequately equipped and sufficiently confident to work with this client group and lack in-depth understanding of the issues involved; however, as only one CMHT member agreed to be interviewed it is hard to draw firm conclusions.

Whatever the reason, third sector organisations are sometimes unable to support individuals presenting with severe mental health problems and report having to refer them back to the statutory mental health services. Issues raised by staff highlight the importance of strengthening alliances between professional groups and working together in ways that recognise, build upon and complement one another's skills and expertise. Training and networking are critical to supporting change.

Further issues arising at an operational level that compromise joint working include difficulties engaging with key stakeholder groups, such as GPs and Accident and Emergency staff, as well as concerns about confidentiality and the sharing of information. Lack of awareness of historical sexual violence in both primary and secondary health care services is identified by survivors and staff and explored below. In relation to confidentiality, staff involved in counselling survivors highlight some of the issues they face in practice; in particular, decisions relating to sharing with other organisations sensitive information that is disclosed during confidential counselling sessions. Counsellors recognise that their reluctance to share information about clients is often perceived as uncooperative by others and as evidence of them working in silo:

> *We find it difficult to work with other organizations because of confidentiality, and confidentiality is just so crucial, I think, to the work we do, that it's very difficult for us to share information at all, and the work that we actually do tends to be very much individually focused... I mean we often get requests for information about particular clients, and you know we have to say well we can't comment, you know, because anything that the client wants to tell you, they can tell you. It's not like we're keeping it a secret, but it's up to the client to tell you. Staff 11.6*

Counsellors report on their preference for signposting survivors and providing them with information about other organisations rather than sharing information directly with these organisations.
Having described some of the challenges associated with effective joint working, it is important to also highlight some of the successes as identified during the course of the staff interviews. These include:

- Significant improvements in relationships between third sector organisations and the police.
- Effective partnerships between specialist survivor organisations and drug and alcohol services that are facilitated by the involvement of the Independent Sexual Violence Advisors (ISVAs).

- Joint awareness raising and training events facilitated by third sector organisations and delivered to the statutory sector; these seek to improve the responses of statutory sector organisations to those individuals affected by child sexual abuse and ensure that their needs are better understood.

Organisations operating under the umbrella of the Survivors Trust acknowledge the important contribution of the Trust in Wales to fostering more collaborative working arrangements. Whilst we observed competition between some third sector organisations and a reluctance to work together, we also identified examples of effective partnerships, including those developed in South Wales by Victim Support and MIND that involve weekly outreach activities, allocated hot desk space in one another's' premises, regular attendance at team meetings and joint support for a small number of survivors who self-harm. As previously noted, there are also examples of survivor organisations linking effectively with community and faith groups.

The positive contribution of the Sexual Assault Referral Centres (SARCs), that are underpinned by a partnership approach to supporting individuals affected by recent or historic sexual abuse, is highlighted by staff across the statutory and independent sectors; in particular, more timely referrals, earlier interventions and the focus on delivering specialist support that responds to *local* needs:

> *Because now the thing we do well, or better, is to get in there quicker. Especially with our working partnership with the SARC, Sexual Assault Referral Centre.*
> *Staff Joint Interview 10.6 & 55.6*

> *… yeah, you've got the support system in the same place, so it's all there at the same time and you don't have the confusing boundaries of cold police person, warm support worker, you know, you've got it there …*
> *Staff Joint Interview 36.6 & 61.6*

The specialist services developed and delivered via the SARCs were described by a number of staff as a *quantum leap* forward; their contribution will be explored in a paper arising from this work.

Lack of awareness amongst key stakeholder groups

Lack of awareness of the issues affecting adult survivors of child sexual abuse amongst key stakeholder groups, in particular, some GPs and nursing staff working in Accident and Emergency Units, is highlighted as a key service delivery challenge that hinders joint

working, impinges on the building of relationships between survivors and professionals and, ultimately, frames survivor perceptions of service quality and future decisions about accessing services. Despite concerted efforts by the research team we were unable to interview anyone from primary healthcare, who may have offered an alternative perspective, and interviewed just one individual from secondary healthcare.

Lack of awareness of historical sexual violence is evidenced in a number of ways. Survivors describe the inappropriate reactions of professionals to the disclosure of explicit and distressing information relating to events that happened during childhood and limited understanding and sensitivity:

> *….professionals I find are very scared about opening big cans of worms to other people… we need to make it acceptable to be able to talk about it and for people to have professional kind of resources and all the skills to deal with that.*
> *Survivor 2.1*

> *I remember the doctor writing a referral, "The patient has confessed to – to um, having been sexually abused as a child"… and then I just couldn't cope, I couldn't cope at work and I'd literally stuffed a load of tablets in the car and gone to the GP and I thought if the GP does not handle this right then I'm out of here and I will do something.*
> *Survivor 9.1*

Following her visit to the GP this survivor attempted suicide.

Appropriate ways of responding to people who disclose about sexual abuse is an important area for future pre and post qualifying training:

> *… a lot of peoples' attitude is (gasp) can't handle that…. Shock, horror and I think that makes things worse… We all do it don't we, we are all human beings and you know, I think we all go "Oh, my God no, that didn't, no" you know it is like that sort of denial oh God you hear something horrible and you know… we all do it and to someone who has been sexually abused it is like hearing oh, you know you are lying.*
> *Staff 62.6*

Survivors are critical of judgemental professionals who project blame, as this serves to reinforce their sense of guilt, shame and low self-worth. They are also critical of professionals who they perceive as probing inappropriately into issues relating to sex, sexuality and

intimacy and/or project a sense of discomfort when talking about sexual abuse:

> *You know there's things that have been said to me like, oh you know shit happens, get over it, and when I disclosed…. they asked the worst questions, they had no idea what they were dealing with.*
> *Survivor 8.1*

The importance of both verbal and non-verbal communication and body language is highlighted. For some survivors the perceived lack of awareness of and sensitivity to the emotional effects of experiencing sexual abuse during childhood generates feelings of anger and resentment:

> *…. the way I was treated was awful. I was told the depression was brought on because of things that had happened to me as a kid and that it was not a "proper" mental health problem. It was though I'd been allowed to go to hospital for a bloody rest. They ask you to talk but then they don't listen; it's almost like they don't believe you. You may as well stop all communication because they just don't bloody listen.*
> *Survivor 29.1*

> *…. the psychiatrist there put me on anti-psychotic drugs without even listening to my story. I wrote to complain. The only thing he did hear was me saying that I self harmed and felt like I wanted to jump in front of a bus. He told me "go home, relax and take a bath" and so I did and I took the razor in the bath and cut myself, slit my entire body until the water ran red with blood. He was very old fashioned, the pull yourself together type.*
> *Survivor 30.1*

For others it leads to feelings of apathy.

Some survivors mention their reluctance to undergo medical procedures such as MRI scans, smear tests and dental treatment; the lack of awareness and understanding amongst healthcare professionals can compound the situation:

> *I had to go for an MRI scan because my hearing's not very good and I hear noises in my ear and I'm claustrophobic, very claustrophobic and that I think comes from the abuse, and I couldn't go in the MRI scanner because um, and they even brought my husband in to hold my hand, all this sort of stuff and I couldn't cope with it. Um, went back to the doctor and*

he just sort of said "Oh well, you can't have the MRI scan, there's nothing I can do about your ears, I can't see without the scan". And I said to him, "Look, I'm really sorry but there is a reason, er, why" and um, he just wasn't interested, he was just like "Tough, you should've been able to cope with it".
Survivor 17.1

This is confirmed by staff:

The other thing that is common, that clients say, is when they have to have interventions, so particularly things like having smear tests, birth, pregnancy, you know, medical examinations of various forms, the lack of kind of – I don't know, ability to communicate sometimes, dentists is another thing some people find really difficult, that often practitioners are not aware of, or it's difficult for them to tell people why it's so traumatic and you know that can often re-traumatise people.
Staff 11.6

Survivors and staff alike are critical of GPs, in particular, what they perceive to be the over prescription of anti-depressant medication and the limited signposting to counselling and other talking therapies that can support individuals to manage trauma and develop effective coping strategies:

I don't think they should be quite so blasé about it. They just have the bog standard….. just lift yourself up and get out of it and be more confident. And then everything will be really happy. And do you want drugs by the way? ... You don't heal a broken leg with a Panodol. You can keep going with the Panodol and it can be as painful as you like, but the leg still stays broken.
Survivor 19.1

GPs try to a point but Prozac doesn't work, people mostly need counselling because their trauma levels are very high.
Staff 30.6

Whilst acknowledging the demands on GP time and resources, survivors emphasise the importance of looking beyond presenting symptoms to understand the underlying causes of problems, such as depression, and behaviours, such as self-harm:
….when I was a teenager, always blind drunk, always smashing things up, again there was no examining on the reasons why I was doing that, hmmm, the medical people…. I'm drinking so much, and I keep having panic attacks and

depression and anxiety, no-one ever asked what it was…The doctors let me down.
Survivor 23.1

The support I've had has been too little too late – I'm 58 for god's sake….You'd have thought someone would have probed into things… Medics need to be aware of the damage that's caused.
Survivor 9.1

Whilst in the main survivor accounts highlight limited awareness of historical sexual violence and its longer term effects amongst healthcare practitioners, there are some examples of good practice where individual members of staff demonstrate sensitivity and awareness, taking time to support individuals, recognise the challenges they face and signpost to organisations that might be able to help:

I had a gall bladder taken out recently and a tear in my bowels which made me very ill and they have to put, um, is it called an endoscope, and endoscopy where they put a camera down there and they put a little stent in my bowels. Oh God, something going in my mouth, I can't bear the dentist doing, you know, my dentist was fine, I've had to explain to them and every time I put my hand up he pulls the equipment out, let's me calm down a bit and goes again. And I – I said to them I'm claustrophobic, "Oh yeah, lots of people say it" and I said, "No, this is why I'm claustrophobic" and they were absolutely fantastic, a nurse sat and held my hand, talking to me, holding my hands all the time because you've got to swallow the tube, then – then they put you off to sleep, then there – you've got this big thing in your mouth, and they were fantastic…. but I think it just depends what person you get.
Survivor 17.1

Survivors recognise the dyadic nature of relationships and their role in the building of relationships with health and social care professionals; this includes the need to communicate openly and honestly, though this is not always easy:

The practice nurse also knows….I have talked very openly about it. Because I had to –when I went for my first smear test at the doctors, I didn't want to have it done. Because yeah? So I explained to them what it was. And she was absolutely lovely. So er....that was a biggy for me. Actually owning up at that time for this smear test about that. She had just been really, really lovely…… But I think its also a two way

thing with GPs. I think if the client communicates with the GP…what is going on in their mind, then the GP will give them the help. If the client is unable to be forthcoming, then the GP can only help so far.
Survivor 35.1

Survivors are critical of the lack of awareness and expertise as well as judgmental responses of nursing staff working in A&E departments when individuals present with self harm injuries and health problems arising from substance misuse; their accounts highlight the considerable scope for improvement if practice is to meet the requirements outlined in the 2004 NICE Guidelines relating to support for individuals who self-harm:

The first time I took an overdose and I did nearly die…. I had to have a tube put down, right down into my – and I remember, it was like that orangey rubber stuff, and it was thick and I fought, it took four people to hold me down, but they weren't gentle… I mean they weren't brutal, but there was no softness and no gentleness at all, and I was very lucky, I hadn't had anything to eat, so therefore, they just poured this stuff – they put a funnel in and just poured this liquid and I was violently sick and I was annoyed – the sound of tablets, I took 200 aspirins and I remember the sound of them going into this enamel bowl, but I don't remember any kind words at all.
Survivor 10.1

This is confirmed by staff:

I think that self harm is emotive and personal. Judgements and prejudice gets in the way… self harm is a biggy with survivors. The best description I have heard of self harm is that is the silent scream. Which I think sums it up for a lot of people that I have worked with over the years.
Staff 4.6

And they bring their personal opinion, their personal beliefs and their personal judgements of what's right and what's wrong into work… And the abuse, unfortunately, is then perpetrated by professionals because how many times in (place) do serial self-harmers end up in a position where they go in there and they're judged, they're not treated correctly because it is seen as self-harm… they're seen as a problem rather than as a patient.
Staff Joint Interview 36.6 & 61.6

They are accused of attention seeking and I think sometimes that lack of awareness you know in general nursing… Certainly the feeling seems to be the nurses are angry with them. It's like you're wasting our time… on this bed, I've got you know somebody who has been run into by a drunk driver. And I've got you sitting here because you decided to cut yourself with a razor blade. But if they haven't got that understanding of the emotional pain then it is going to be difficult for them.
Staff 7.6

The important contribution of specialist survivor organisations to raising awareness amongst health and social care professionals working across the statutory and independent sectors is highlighted.

Summary

In summary, this chapter highlights key issues relating to the nature, availability and delivery of support to adult survivors of child sexual abuse. Drawing on survivors' narrative accounts, as well as staff perspectives, it identifies the main service delivery challenges that organisations, in particular those in the third sector, face in seeking to provide flexible and responsive services that are sensitive to the immediate and longer-term support needs of individual survivors. Limited funding is especially problematic and significantly affects the ability of both statutory and third sector organisations to build service capacity and address current gaps in provision; these gaps include support for families, on-going, non-therapeutic help that addresses survivors' emotional, practical and advocacy needs, as well as the development of specialist services for male survivors. Recommendations to inform future service development are made in the next chapter.

Chapter 5 Conclusions and Recommendations

Introduction

This report presents key findings from our research looking at the experiences and support needs of adult survivors of child sexual abuse. In this final chapter we summarise the findings from the survivor narratives and staff accounts under three main headings, namely, relationships, individual life journeys and stigma; the synthesis of findings under these three headings provides a useful framework for thinking about survivor experiences, as well as informing recommendations for future policy, practice and service development.

Further in-depth analysis of the data will be presented in forthcoming papers and conference presentations arising from this work.

Summary of key findings

Relationships

Survivors spoke about the challenges of establishing and maintaining relationships throughout their adult life. This includes establishing and maintaining sexual relationships with partners, maintaining relationships with (non-abusing) family members, forming lasting friendships and establishing relationships with the various professionals they come into contact with. Underpinned by issues relating to trust and seeking safety, these difficulties serve to further reinforce feelings of isolation and, for some, foster a sense of fear, anxiety and impaired self-efficacy. Staff highlight the dearth of support available to help individuals who are experiencing relationship difficulties and address their feelings of social exclusion. This includes support to break cycles of abusive relationships (sexual, emotional and/or physical) that recreate emotional and behavioural patterns learnt in childhood and can leave survivors at high risk of subsequent re-victimisation.

Being believed is critically important at the point of disclosure and thereafter; it is central to the building and maintaining of relationships with others and to the survivor's individual journey. The overwhelming sense of betrayal described by some survivors, who as a child had confided in a family member or other adult who did not believe them, carries over into adulthood with enduring consequences. It can adversely affect other relationships and reinforce a sense of low self-esteem, guilt and shame. For some,

establishing emotional and geographical distance from parents and siblings is an important coping mechanism.

Some survivors spoke about their sense of anger and resentment towards family members and/or professionals who they feel should have a) recognised that something inappropriate was happening to them during their childhood, b) taken steps to protect them from the perpetrator and c) supported them to seek help. This includes parents and siblings, as well as GPs and school teachers. For some survivors, their limited confidence in the ability of others to protect them during childhood shaped their general expectations of relationships in adult life. Indeed, it sometimes influenced their decision to delay disclosure until late adulthood and/or seek professional help.

Individual life journeys

Whilst survivors describe a number of common experiences, in particular, their sense of guilt, shame and feeling disconnected, their individual journeys (characterised by *seeking support, moving towards healing* and *moving on*) are complex and unique. Survivors invest a great deal in seeking to be in control as they embark on their journey; however, present service organisation and delivery arrangements are often inflexible and lack responsiveness to the individual's lived experiences, personal preferences and priorities. This can reinforce survivors' sense of powerlessness. Limited joint working and effective signposting compound the situation; survivors are frustrated by the *revolving door* of service organisations, which results in their support needs being missed or remaining unmet.

Survivors reflect on the importance and perceived helpfulness of specialist counselling services, specifically in seeking to help them:

- Make sense of events that happened during their childhood.
- Progress on their journey.
- Assume greater control over their lives.
- Address negative thought patterns (including flashbacks and self-blame) and behaviours (including the miss-use of alcohol, drugs and food and self-harming activities such as laceration).

The important contribution of third sector organisations in delivering such provision is recognised by survivors and staff alike; however current funding deficits mean that the sector is unable to realise its full potential and, despite the best efforts of staff, flexibility and innovation are stifled. There are a number of serious and prevailing gaps in service provision, which we identify (below) in our recommendations for future policy, practice and service development.

As noted, seeking to be in control is important to the survivors that we spoke to in coming to terms with and managing the sequelae of childhood sexual abuse; participation in paid employment and/or opportunities to volunteer or study can help to support this, yet there is a dearth of service provision to help adult survivors with employment or education related issues. This includes help to secure employment and to address matters arising in the workplace, for example, problematic relationships with colleagues.

Stigma

Survivors reflect on the raft of negative emotions they experience; this includes speaking about the pervasive effects of guilt, shame, low self-worth and a disrupted sense of self, which they suggest are inextricably linked to the prevailing stigma associated with child sexual abuse. Taboo, its very existence challenges the accepted view of a civilised society which places a high value on the safe care, development and nurturing of children and protection from harm and exploitation.

Stigma serves as a barrier to accessing much needed help and support from friends and family as well as professionals. Sometimes the reactions of staff to disclosures of sexual abuse during childhood, as well as their reactions to highly sensitive, intimate information and/or strong emotions towards the perpetrator serve to further reinforce the survivor's sense of stigma, as do professional expectations of what survivors might aspire to and achieve in their lives. The limited sensitivity evident amongst *some* professionals can compound the difficulties survivors' face, project blame, inhibit the building of relationships with professionals and discourage individuals from seeking further help; this includes seeking help with serious, longstanding mental health problems such as depression and anxiety-related disorders. Future service development work must be underpinned by increased awareness and understanding of the stigma that survivors feel.

Survivor narratives suggest that events that happened during their childhood were a major contributing factor to a range of seriously disabling behaviours and events, including self-harm and, in some cases, attempted suicides. Most had complex care and support needs. Health and social care practice is reactive; the focus lies in treating the presenting symptoms and minimising the immediate harm rather than supporting survivors to explore aspects of their sexual abuse history or to develop strategies for coping positively with day-to-day life. This includes strategies for addressing feelings of stigma and shame.

Recommendations for future policy, practice and service development

We now move on to consider the issues that policymakers, practitioners and service providers might find helpful in seeking to bridge the gap between policy and practice and promote future good practice to support adult survivors of child sexual abuse and their families. Whilst the discussion is based on our work with a specific group of individuals, the recommendations also have direct relevance for and wider applicability to other vulnerable adults.

Our research findings highlight key areas where the organisation and delivery of services might be improved, as well as priorities for future service development. Areas for service improvement reflect the need to:

- Address funding deficits, as reported by third sector organisations.
- Strengthen partnership working between key stakeholders.
- Deliver more flexible and diverse support.
- Improve choice and respect the personal preferences of adult survivors, particularly in relation to gender and language.
- Promote greater awareness, sensitivity and understanding amongst frontline service providers and the general public of some of the longer term challenges that *may* affect adults who experience sexual abuse during childhood.
- Monitor the effectiveness of support provided.

Address funding deficits, as reported by third sector organisations
Our findings highlight the urgent need to address funding deficits and to prioritise monies for specialist third sector organisations that make a unique and important contribution to supporting individuals to manage the long-term effects of having experienced sexual abuse during childhood. In particular, they illustrate the importance of adopting a more strategic approach to addressing *historical child sexual abuse* that has allocated ring fenced funding from the Welsh Government for services that are distinct from those allocated to individuals who have experienced *domestic violence*. This includes pump-priming monies to encourage the development of *new* services as well as resources to fund the much-needed expansion of *existing* specialist counselling services.

To date there is no national strategy for survivors of childhood sexual abuse in Wales or England. However experiences gained in Scotland might be helpful, where a National Strategy for Survivors of Childhood Sexual Abuse was established in 2005 (Scottish Executive,

2005). *Survivor Scotland* aims to enhance the health and wellbeing of survivors by:

- Raising awareness of childhood abuse and its long-term consequences.
- Investing in the continued improvement and expansion of services.
- Overseeing a national training programme for frontline staff.

Survivor-centred, the Scottish Strategy describes a way forward to improve services and ensure greater joined up working in local statutory and third sector services; it allocates £850,000 of pump-priming monies (2011/2012) for applications to develop *new* services that address support for survivors who are: experiencing complex physical and/or mental health problems; members of ethnic minority communities; serving prison sentences; or, living in remote rural areas. Up to £25,000 is available for each application for twelve-month project funding.

Presently, chronic under-funding within the sexual violence field in Wales makes it extremely difficult for third sector organisations to: formulate long-term service delivery plans for local, targeted support; recruit, train and, critically, retain experienced members of staff; and, deliver specialist training to key stakeholders and professional groups. Reliance on short-term, non-recurring grant funding is problematic; it is important to take steps towards building capacity and sustainability amongst specialist organisations in order to ensure continuity of service provision and support. Referrals from the statutory sector, including from CMHTs, primary care and the police, should be underpinned by Service Level Agreements that meet the full costs of providing core services and reflect the increase in client numbers. Such steps should help to address the retrograde practices occurring at an operational level when third sector organisations compete rather than collaborate with one another for increasingly limited funds.

Funding limitations in the sexual violence sector mean that it is difficult to deliver the types of long-term support that survivors highlight as being critically important on their journey towards healing and moving on. Whilst research (Rovi *et al*., 2004; Astbury, 2006) has previously established that difficulties in accessing timely, appropriate support can heighten the long-term physical and psychological trauma experienced by adult survivors as well as increase their reliance on statutory services (including mental health services, emergency services, outpatients and primary and specialist care), organisations continue, *by necessity*, to prioritise crisis intervention activities and waiting lists for specialist counselling

remain at unacceptable levels. Funding is required to enable the expansion of specialist counselling services (which survivors praise for their sensitivity and depth of understanding), as well as address some of the key gaps in provision, which we described in Chapter 4 and highlighted as priority areas for future service development. This includes counselling (face-to-face and on-line) for:

- Male survivors.
- Families and significant others.
- Transgender survivors.
- Perpetrators who are themselves survivors of child sexual abuse.

In addition to funding therapeutic services, monies need to be made available to enable organisations to offer ongoing emotional, practical and advocacy support (see below).

Strengthen partnership working between key stakeholders
Successive health and social care policies underscore the importance of working jointly to support vulnerable individuals and their families. Key policy initiatives, including *Designed for Life* (Welsh Assembly Government, 2005), *Fulfilled Lives* (Welsh Assembly Government, 2007), *Designed to Add Value* (Welsh Assembly Government, 2008) and *Sustainable Social Services* (Welsh Government, 2011) reflect the need for partnerships across the statutory and third sectors, underscore the importance of shaping provision around vulnerable individuals and their families and acknowledge the need to rebalance services towards the community, including local provider development and partnership arrangements. Additionally, the SARCs provide a blueprint for joint, whole systems working; they are tasked to provide referral pathways to support individuals with a history of past sexual abuse and they seek to reduce duplication, deliver more seamless support across organisational boundaries and ultimately secure better outcomes for those affected by sexual violence. Whilst the staff we spoke to are committed in principle to the policy ideal of working jointly across organisational and sectoral boundaries, our findings illustrate the challenges associated with translating policy into practice; in particular, issues arising at an operational level can frustrate the development of synergistic relationships and efforts to work together. Experiences related by survivors and staff alike highlight a series of enduring challenges and missed opportunities.

Central to a partnership approach is listening to and valuing the contribution of others. Therefore, a crucial first step to improving joint working and effecting positive changes in practice in the field of historical sexual violence is to develop a clearer understanding of the

roles, responsibilities and complementary skills of respective stakeholders; hopefully this will help to encourage more effective partnerships and address some of the difficulties relating to inappropriate referrals, in particular, from CMHTs to third sector organisations, as well as encourage the sharing of expertise and good practice. Developing and agreeing shared systems of working that encourage confidence and trust in the professional judgements of others is critical to addressing inappropriate referrals.

The advantages of joint working, in terms of the quality of service(s) delivered to clients, as well as the financial benefits, need to be made explicit in order to: quell the culture of competition that is evident amongst some third sector organisations; reinforce the shared nature of responsibility for supporting this vulnerable client group; and, encourage the development of effective local partnership arrangements. Joint training is central to achieving change, supporting high levels of competence and realising the Welsh Government's strategic goal of supporting alliances which promote the health and wellbeing of vulnerable individuals and their families. Indeed, the Social Care Workforce Strategy recognises workforce training as central to the transformation of services; it aims to support workers in promoting more seamless, person-centred care (Care Council for Wales, 2008). In order to ameliorate some of the concerns highlighted by survivors relating to the fragmented nature of current service provision we suggest that future training should routinely incorporate discussions about organizational, policy or practice barriers to joint working.

Opportunities to discuss and develop joint initiatives via the existing Wales Learning and Improvement Networks (LIN) should be sought – including the Citizen Directed Support LIN for Wales and the Housing LIN. In addition we suggest that a specific Sexual Violence LIN for Wales be established to:

- Promote greater collaboration.
- Facilitate discussion of the key issues and challenges affecting those who work in the sexual violence field.
- Raise awareness.
- Encourage the cross fertilisation of knowledge and practice exchange.
- Develop new and innovative ways of working.

Key stakeholders would include representatives from:

- Specialist survivor organisations.
- Education.
- Health and social care.
- Housing.

- Police.
- Criminal justice sector.
- Independent Sexual Violence Advisors (ISVAs).

Deliver a more flexible and diverse range of support

Whilst there is no blue print for effective service provision given the diversity of situations and circumstances that adult survivors and their families face, our findings highlight the need for greater flexibility in the commissioning, organisation and delivery of support that takes into account the individuality of survivor experiences, family circumstances, life roles and support needs, as well as the need to respond to sudden crises.

Innovative thinking around service design and delivery in order to develop timely, creative responses to individuals in need is required. In particular, specialist sexual violence counselling services (usually delivered via third sector organisations) need to be enabled to be more flexible in terms of their nature, timing, location and duration; presently, practice is hindered by financially driven priorities which temper expectations of what can be achieved and prevent potentially innovative solutions (including the delivery of online support) for survivors and their families even being tried. Support is mostly delivered at the providers' convenience; the extensive travel distances (sometimes using public transport) to see specialist counsellors are unhelpful and can add to the distress experienced. Also, the scheduling of counselling sessions during the daytime can make it difficult for those with paid employment commitments and/or childcare responsibilities to attend.

Paradoxically, although the challenges faced by survivors in their everyday lives are sometimes very complex and their individual journeys very difficult, solutions sought by survivors are often simple, for example, someone to talk to or spend time with. Our findings highlight the importance of on-going support (non-therapeutic) to help survivors in the longer term; this includes:

- Practical support - for example, help with seeking employment or finding suitable housing.
- Social and emotional support - for example, help with establishing relationships and overcoming feelings of isolation and loneliness.
- Advocacy support - for example, help to understand the benefit system or to liaise with employers about difficulties experienced in the workplace.

As noted, experiences related by staff suggest that in the present economic climate it is extremely difficult for third sector

organisations to attract funding for these types of support, which are often perceived as non-essential. It is important to recognise the important contribution of such support to survivors as they embark on their individual journeys, particularly given the time limited nature of most specialist counselling provision. Such support can complement therapeutic interventions by helping individuals to develop new skills, as well as contribute to building confidence and social networks. The survivors we spoke to report that help to find and retain paid employment is particularly important as it contributes to financial independence and standards of living as well as to their sense of identity and self-worth.

Embracing the potential of local community organisations and faith groups to provide this type of support might be helpful; whilst ideas about developing networks of local supporters are not new, they sit comfortably with the growing evidence base about effective ways for supporting vulnerable adults in their own communities. Clearly, any programme that seeks to develop networks of local supporters would need to take into account a broad a range of issues, including the level of demand in localities, the requirements for competent performance and sensitive delivery, as well as stringent monitoring arrangements, training and channels of communication between respective stakeholder groups. Such arrangements must also have the capacity to support people as their circumstances and support needs change over time. Pan-Wales good practice guidelines to underpin the delivery of such services and support would be helpful.

Improve choice and respect the personal preferences of adult survivors

Our findings illustrate the individual journeys that survivors embark upon.   If the principles of person-centred, outcome-focused provision enshrined in successive Welsh Government policies are to be realised, more individualised and inclusive approaches to the commissioning of services need to be developed. Work by Bennett (2008) looking at commissioning for personalisation highlights the importance and potential of such approaches and also outlines a helpful framework for Local Authority commissioners.

Change and development is needed at the provider level to create opportunities that make a positive difference; this includes opportunities for survivors and their families to shape innovative solutions to the challenges they face.   Given that they are a notoriously difficult to reach group, a multifaceted approach to consultation and involvement is required though greater use of community groups and resources. Combining consultation with opportunities to meet with other survivors and for peer support has some merit, but of course would not be appealing to all.

Commissioning organisations must work more closely with survivors to develop responsive provision that is capable of supporting individuals to achieve a variety of *personalised* outcomes, including social and emotional outcomes that are important in shaping wellbeing and quality of life and helping individuals overcome trauma in their lives. Responsiveness to individual needs is critical if key policy objectives that relate to promoting equal opportunities, reducing health inequalities and promoting social inclusion are to be realised. A common set of performance indicators may prove useful (see below). However, it is essential that support is *individualised* and outcome-focused rather than target led and that creativity is not stifled.

Personal preferences, for example, counselling that is sensitive to gender and language preferences and compliant with the Gender Equality Duty (2007) and Welsh Language Act (1993), need to be accommodated. Concerted efforts are required to recruit more male counsellors and Welsh language counsellors to the sexual violence field. Also, greater attention needs to be paid at a strategic level to the effects of historical sexual violence against men and the dearth of services across the age spectrum for male survivors. Present strategies, for example, *The Right to be Safe*, which is the Welsh Government's six-year integrated strategy for tackling all forms of violence and domestic abuse, focus mainly on women.

Our findings suggest that whilst professionals are often aware *in principle* of the importance of offering language choice to adult survivors, in practice they are not always able to understand and analyse that choice. Recent work conducted for the Care Council Wales by Davies (2010) *Different Words, Different Worlds* is helpful in understanding and exploring the concept of language choice in social work and social care, as well as the implications for practice and service delivery. The case studies and points for discussion have wider applicability and would be helpful to the varied professionals across the statutory and third sectors who are involved in supporting adult survivors in Wales. In particular, this work highlights that language choice for bilingual individuals is a complex process that involves much wider influencing factors than political, legal or emotional ones.

Promote greater awareness, sensitivity and understanding amongst frontline service providers and the general public

In addition to thinking more flexibly and creatively about ways to meet survivor needs, it is important to promote greater awareness, sensitivity and understanding amongst commissioners and frontline service providers, in particular, to disclosures of sexual abuse during childhood and the longer term challenges that *may* affect individuals

during adulthood. Experiences related by survivors suggest that some service staff are insensitive and fail to provide for safe disclosure; their reactions to disclosures and other highly sensitive information can project blame onto survivors, intensify survivors' feelings of guilt and shame, reinforce their sense of sigma and heighten their vulnerability to re-victimisation.

Providers must consider how they might address the poor reputation of statutory health and social care services, in particular, the low expectations some individuals have of receiving sensitive, responsive support and their limited confidence in service provision. This includes when individuals present at A&E units with self-harm related injuries; ensuring compliance with the 2004 NICE Guidelines on the management and secondary prevention of self-harm is a critical first step.

It is essential that awareness raising and understanding of historical sexual violence is integral to *accredited* training (pre and post qualifying) across the spectrum of health and social care professions, as well as those working in the education sector, and also to continuing professional development programmes. There are some useful guides and examples that professionals can draw on such as *Yes you Can!,* a guide developed for people working with, or likely to be working with, survivors of childhood sexual abuse (Nelson and Hampson, 2008). The Survivor Scotland website also highlights some examples of good practice but there is generally a lack of available training materials and continuing professional development programmes across the UK.

Actively seeking opportunities to involve survivors and their families in the development and delivery of training programmes and drawing on their first-hand experiences is important in terms of staff gaining a clearer view of survivor-defined outcomes and the longer term effects of child sexual abuse, as is availing of the expertise of *specialist* third sector organisations. Along with training, workplace monitoring and on-going encouragement of good practice are essential.

Our findings also highlight the potential usefulness of a Pan-Wales or UK wide awareness raising campaign that highlights the long-term effects of child sexual abuse and the services that are currently available to support individuals. Examples of existing campaigns are the UK-wide Stop It Now! Campaign (www.stopitnow.org.uk/), which runs specific projects in the different UK regions. A focus on prevention as suggested by Survivor Scotland may also be helpful, such as:

- Schools programmes, which try to help children protect themselves from abuse and harm.
- Programmes with convicted perpetrators, which seek to reduce their re-offending.
- Making the general public more informed, aware and observant.
- Making detecting offenders a priority.
- Supporting safe parenting.
- Funding safe childcare.
- Reducing risks in the physical environment.

These approaches and campaigns link with wider initiatives tackling stigma and mental ill-health such as *Time to Change*.

Monitoring the effectiveness of support provided
Assessing performance and reviewing the effectiveness of support to survivors and their families are critical. Our findings suggest that organisations need to actively involve survivors in measuring the effectiveness of policies, initiatives and services that are designed to support them. In particular, organisations should make more concerted efforts to capture survivor perspectives on the *quality* as well as the *quantity* of support received. This information is vital in developing a sound evidence base about the effectiveness and *continuing* effectiveness of support. To date, global measures, such as satisfaction with services as reported by in-house or independent surveys, the number of individuals on organisational mailing lists and the number of new survivors referred to services focus on the *quantity* of provision available rather than *quality* of survivors' first-hand experiences.

Survivors' personal experiences as they embark on their individual journeys are fundamental to defining and evaluating outcomes; this presents a number of challenges for practitioners, not least because of the diversity of experiences they report. However, in measuring outcomes, organisations should consider:

- Are services consistent with the priorities and intended outcomes identified by survivors and do they match their expectations?
- Do survivors regard services as relevant and responsive to their individual needs?
- Do services make life easier for survivors and their families, taking into account their coping strategies?
- In what ways might services be improved and the timescales for improvement?

Recent work by the Survivors Trust (2010:64) outlines a number of more detailed, sector specific outcome measures that might be helpful in terms of monitoring and evaluating the quality and effectiveness of support to survivors and their families, including:

- Quality of life measures.
- Changes in:
  - Drug/alcohol use/other lifestyle changes.
  - Employment, career and education.
  - Relationships with others.
  - Mental health, including reduction of self-harm.
  - Reliance on medication.
- Assessment of the client's perspective on what works in counselling and support, for example, number of sessions, model of support.
- Impact of support on wider family and victim's children.
- Age of disclosure; perpetrator characteristics.
- Soft outcomes, for example, levels of happiness, self-esteem.
- Assessment of vulnerability to re-victimisation.
- Measures specific to survivors who experience complex dissociative disorders.

Our findings support the need for flexible outcome measures in order to:

- Encompass the many and varied aspects of provision.
- Inform present and future service development activity.
- Meet the monitoring requirements of funding organisations.

Decisions relating to the use of outcome measures should of course be taken in consultation with survivors and their families.

Dissemination activity

The research team will be presenting the following paper:

Supporting individuals who experience sexual abuse during childhood

National Congress, British Association for the Study and Prevention of Child Abuse and Neglect, Queens University, Belfast, April 2012.

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Appendix A: Topic Guide – Staff Interviews

Adult survivors and their families: current needs and service responses

Introduction

This study seeks to inform developments in policy, practice and service provision to better meet the needs of adult survivors of childhood sexual abuse and their current families. It is funded by the National Institute for Social Care and Health Research on behalf of the Welsh Assembly Government.

We are interested in your experiences of supporting adult survivors and their families – what works well and areas where policy and practice might be improved. Later on, we will also be speaking to adult survivors and their families, across Wales, to ask them about their experiences of assessment and service provision.

Consent
- *"Before we start, I need your consent to record this interview."*
- *Sign consent to record interview form.*
- **Press record on MP3 player:** *"The interview is now being recorded...."*

Tell me about:
- Your role and the ways in which you are involved in supporting survivors and their families:
  - Nature of role.
  - Challenges this role presents.

- Nature of challenges facing adult survivors and their families:
  - Everyday lives – health, relationships, employment, and housing etc.

- Dealing with disclosures:
  - What this involves and the support available at this time.
  - Exploring potential support needs.

- Information/outreach strategies in your area:
  - Types of information out there – e.g. in terms of who to contact for support; support that might available.
  - Think about any information gaps – where are they, how might they be addressed.

- Signposting to other organizations and your understanding of other organizations' roles and responsibilities:

- Other support that is available out there and how it seeks to help survivors and their families.
- How your organisation links in/works with other organisations.

- Your thoughts on services, collaborative arrangements and inter-agency responses:
  - Perceived strengths and weaknesses of current services available locally/nationally.
  - Models of service organization and delivery.
  - Planning care and coordinating complex cases – who is involved, their roles and responsibilities.
  - Priorities for future service development.
  - Examples of good practice.

- Identifying and addressing unmet needs:
  - How you set about doing this.
  - Any specific unmet needs that you identify on a regular basis.

- Working to current policy and practice guidelines:
  - Tell me about those which are relevant to your particular field.
  - Ways these help/hinder supporting survivors and their families.
  - Current gaps and how these might be addressed.

- Provision for Welsh language support.

- Staff training:
  - Existing staff training provision – what this covers, usefulness and effectiveness.
  - Any training and support needs and how these might be met.

Close
A key message to inform policy and practice development.

Appendix B: Interview Schedule – Survivors

The interview approach is based on the biographical narrative interview method (BNIM) by Wengraff (2009) and will be conducted in three phases: phase 1 elicits individuals personal experiences in their own words; the aim of phase 2 is to clarify any issues and collect more detail about specific incidences or areas of interest in the narrative, and phase 3 allows asking more structured questions.

Before the start of the interview:
- Familiarise yourself with the protocol
- Go through issues around consent (such as recording the interview, awareness of issues around confidentiality, and ability to terminate interview at any time) and assure that the interviewee has signed the consent form
- Have a copy of the information leaflet in case there are any questions before the interview and also to leave with the interviewee.
- Take leaflets from Napac

PHASE 1
Framing: As you know we are interested in the lives and experiences of adults who have survived sexual abuse in childhood. In a moment, I am going to ask you to please tell me your story: all the experiences and the events that have happened *during your adult years* and are important for you personally. We don't need to know the details of the abuse.

Start wherever you like and take all the time you need. I will listen and I won't interrupt you. I'll just take some notes in case I have any further questions for after you have finished telling me all about it.

Generative question: So, can you please tell me your story as an adult who has experienced sexual abuse as a child[1] –all the events and experiences that have been important to you personally during adulthood. Please start wherever you like and take all the time you need.

Additional prompts once interviewee has finished
▪ *Is there anything more you would like to add?*
▪ *Does anything else come to mind?*

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[1] Need to gauge appropriate term and pick-up how people talk about themselves – some people might prefer survivors of sexual abuse, others might not like it/have never heard it

- *Thinking back about what you've said so far, is there anything else you'd like to say to make sure I understand fully what you've told me?*

CHECK if the interviewee would like a break. Turn off the recorder during breaks.

PHASE 2
Interviewer to select a number of cue phrases from the list made during phase1. The decision of how many cue phrases to use depends partly on the length of phase 1. It is useful to rank the cue phrases. Cue selection should be based on the following: strong emotion words, particular incidence, research aim relevance, or apparently irrelevant remark.
I noted down some key points as you were telling me your story and I would like us to go back and talk about these some more:

You said [cue-phrase 2-6 words]. Can you remember a particular [magic word]… how it all happened

Magic words: *Situation, happening, event, incident, occasion, time, day, memory of a moment, example*

If the interviewee cannot remember/ give no specific example keep asking; if nothing is forthcoming, ask the negative – *"Can you remember a particular [magic word] when X did not happen?*

PHASE 3 Semi-structured questions
CHECK if the interviewee would like a break
- Select the topics very carefully (or adapt as appropriate) from the following list
- If the interviewee has already touched on some of the points summarise these and ask if there is anything else to add.
- If the interviewee has discussed a topic in detail, do not go over the same ground again
- Use phrases such as the following to introduce specific topics:
    - You have already mentioned a number of challenges such as………, can you please tell me a bit more about X
    - You have talked about your experiences with…., can you tell me a bit more about X
    - Please tell me a bit more about X

You have kindly told me your story, about your life as a survivor of abuse and talked about your experiences. I now have some specific questions that I would like to ask you. There are not right or wrong answers. Please take as long as you like to think about and answer them.

Topics to explore if not mentioned or to explore further:
- Specific challenges around retaining paid employment; housing; undertaking education and training; making friends
- Coping strategies, including an exploration of the potential value of meeting with other survivors.
- Information – accessing; assimilating; timeliness; relevance; gaps.
- Establishing relationships with professionals, discussing their experiences and needs with them.
- Experiences of assessment – process; focus; involvement in decision-making; perceived sensitivity; aspects of the process that worked well; aspects of the process that were problematic.
- Services – accessibility; sensitivity; timeliness; effectiveness; integration and coordination; gaps; priorities for development/future services.
- Support from the Criminal Justice system.
- Support from family/friends/peers.
- Unmet needs and how these might be addressed.

More generic questions that might be useful:
- *Based on your experience, how do you feel about service provision and support? Please tell me about any barriers that you have encountered.*
- *Based on your experience, can you suggest anything that you think would improve service provision for you in the future?*
- *Based on your experience, what has been helpful/not helpful for you in terms of services OR what would you have liked but did not get?*

Closing question:
- *Is there anything else that you would like to tell me or ask me, perhaps something that you were expecting us to talk about that we have not covered?*

Close: leave debriefing sheet and discuss the possibility of an interview with a significant other; leave an information pack if appropriate.

Debriefing
The recorder should be turned off for the debriefing session. The interviewer might ask if the interview has brought-up any difficult thoughts or feelings.

The interviewer should leave the interviewee on a 'positive note'. If the interviewee is troubled, the interviewer can offer to contact

someone on their behalf or stay with them while they contact a friend or other sources of support.

Make the interviewee aware of options such as:
- discussing any troubling matters with an appropriate professional, such as a counsellor, social worker or GP, at a later date
- sources of support (leave a debriefing sheet – see below - with the research team's contact details and a range of support organisations)

Appendix C: Debriefing Sheet

Adult survivors and their families – current needs and service responses

Thank you very much for talking to us, your contribution is very valuable and very much appreciated. Please be assured that all the information that you have shared with us will be treated in the strictest of confidence.

Contact details
Diane Seddon   Phone: 01248-388728   Email: cnsr@bangor.ac.uk

Sources of support
Here is a list of support organisations you might find useful. You will also find the web site for the Survivors Trust where you can find information about services in your area. Most of the organisations listed provide a range of information on-line.

Napac – National Association for People Abused in Childhood*:* This is a national organisation focused on supporting adults who have been abused in any way as children. You will also find a list of other support groups on their web site.
Helpline 0800 0853330; *website*: http://www.napac.org.uk; *email*: info@napac.org.uk

Survivors UK*:* This charity provides information, support and counselling for men who have been raped or sexually abused. Counselling sessions are only available at their base on London but they provide a helpline 7 – 9.30 Monday, Tuesday and Thursday.
Helpline 0845 1221201; *website*: http://survivorsuk.org/

Victim Support*:* This is a national charity giving free and confidential help to victims of crime, witnesses, their family, friends and anyone else affected across England and Wales.
Helpline 0845 3030900; *website*: http://www.victimsupport.org; *email*: supportline@victimsupport.org.uk

Samaritans*:* Samaritans provides confidential non-judgemental emotional support, 24 hours a day for people who are experiencing feelings of distress or despair.
Helpline 08457 909090); *website*: http://www.samaritans.org/; *email*: jo@samaritans.org*;*

Voice UK: This is a national charity supporting people with learning disabilities and other vulnerable people (and their families and carers) who have experienced crime or abuse.
Helpline 0845 1228695; *website*: http://www.voiceuk.org.uk

Call – Community advice and listening line: This confidential helpline offers emotional support and information on mental health to anyone concerned about their own mental health or that of a relative or friend.
Helpline 0800 132737; *website*: http://www.callhelpline.org.uk

Mind and Mind Cymru: Mind provides information and advice on good mental health. Mind Cymru has a network of 20 local Mind associations throughout Wales where you can access services such as information and advice.
Website: http://www.mind.org.uk/mind_cymru

Survivors Trust: The Survivors Trust is a national umbrella agency for over 120 specialist voluntary sector agencies providing a range of counselling, therapeutic and support services working with women, men and children who are victims/survivors of rape, sexual violence and childhood sexual abuse. You can find services in your area on their *website*: http://www.thesurvivorstrust.org