

I'll be a survivor for the rest of my life

Adult survivors of child sexual abuse and their experience of support services.

Emma Bond
Fiona Ellis
Jenny McCusker





**Hear me.
Believe me.
Respect me.**

#Focusonsurvivors

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I was probably nine years old. I didn't understand that it was abuse at that time. *I thought I was dying. It was my brother that had abused me. I thought I was dying and so I had a bath and just wanted to go to bed. I woke up the next morning. I wasn't going to school. My mother had mental health problems so, I could get around it. I sat all morning waiting to get her attention... it must have been late morning and she looked at me. I meant to say my brother had made me sick but instead I said she'd made me sick. So it all came out wrong.*

Wendy

.....

Support for Survivors

With this report, we're aiming to give a voice to the survivors who have painstakingly described their journeys towards effective support services, giving us great insight into how we could improve our systems and attitudes in the hopes of improving responses for future generations. Some of what is contained in the following report may be very difficult to read, but that should not stop us from printing it, as these stories need to be told. But please ensure you take care of yourself. Whatever your circumstances, if you feel that you need advice or support, please contact one of the following organisations:

Suffolk

Survivors In Transition (SiT)

Provides support for men and women who experienced sexual abuse in childhood, as well as men who have experienced sexual assault in adulthood.

01473 232499
support@survivorsintransition.co.uk
www.survivorsintransition.co.uk

Fresh Start-new beginnings

Works throughout Suffolk and Norfolk and was set up to provide a therapeutic service for children and young people up to 21 years of age who have reported being sexually abused, offering support for their families, too.

Head Office: 01473 353355
Norfolk Office: 01603 558205
<https://www.fsnb.org.uk/contact-us/>

Suffolk Rape Crisis

Provides support to women and girls aged 14 and above who have experienced any form of sexual violence.

01473 231200
<http://www.srchelp.org.uk/home/contact-us>

The Ferns

Is a Sexual Assault Referral Centre providing free support to all those who have been affected by sexual abuse.

0300 123 5058
<http://www.theferns-suffolk.org.uk>

National

Safeline

A leading specialist national charity for sexual abuse and rape.

<https://www.safeline.org.uk>

Rape Crisis England & Wales

A national charity and the umbrella body for the network of independent member Rape Crisis Centres.

<https://rapecrisis.org.uk>

The National Association for People Abused in Childhood (NAPAC)

The UK's leading national charity offering support to adult survivors of all types of childhood abuse, including physical and sexual, as well as emotional abuse and neglect.

<https://napac.org.uk>
0808 801 0331



*I always say, **it's not what happened to you, it's what it leaves you with.***

It's the effect it has on your education, your relationships, attitudes, all sorts of different ways, the way in which your fears manifest, it's everything, trust, blame.

Cathy
.....

Being listened to, believed and respected

Following on from the 2015 national survey 'Hear me, Believe Me, Respect Me' conducted by Noel Smith, Cristian Dogaru and Fiona Ellis, the focus in this study is underpinned by the key findings from that survey. In the interviews we conducted, as in the 2015 survey, questions about being listened to, believed and respected were based on the results from the Q-sort and the advice from a service-user reference group from Survivors in Transition (SiT).

From the group's perspectives, these questions reflected essential basic qualities that services needed to have in order to help adult survivors of child sexual abuse. Being listened to is essential for survivors who, as children, lacked a voice or were ignored. Being believed is essential for survivors who, as children, would often be warned by their abusers that if they told anyone of the abuse they would not be believed. Being respected is essential for those who felt degraded by their abuse.

For more information about this study, please contact

Professor Emma Bond

(e.bond@uos.ac.uk)

or

Fiona Ellis

(fiona@survivorsintransition.co.uk).

Focus on Survivors

Acknowledgements

The authors would like to thank Jenny McCusker for all her help with the fieldwork and analysis of the verbatim data. Without her hard work, commitment and dedication this study would not have been completed within the timeframe.

We would also like to acknowledge the important contribution made by the service-user group at Survivors in Transition who played a vital role in the design of the research and interpretation of results. The group's support, insight and expertise is greatly appreciated. Above all, we are indebted to the 28 survivors who volunteered to talk about their experiences of trying to get help and support following childhood sexual abuse, without whom this study would not have been possible. All the survivors interviewed have shown extreme courage and insight and their views will undoubtedly impact service provision going forward.

The University of Suffolk



The University of Suffolk is a cohesive, self-critical and student-centred academic community. Our vision over the next five years is to develop a broader base, be of higher academic standing, with a larger student population drawing from the region, nationally and internationally. The University will be underpinned by an embedded scholarly base, with nationally and internationally recognised research in targeted areas. Our role as a community impact university will be having a clear, measurable and positive impact on the economic, cultural and educational lives of the communities we serve. The University of Suffolk is very proud to be home to a vibrant and dynamic research community with a range of specialist academic expertise.

In a rapidly changing and increasingly globalised world, our research is agile, responsive, collaborative, and grounded in robust scientific and ethical approaches.

Suffolk Institute for Social and Economic Research (SISER)



As a well-established research institute at the University of Suffolk, SISER aims to inform real-world public policy by providing an innovative approach to interdisciplinary research and a high-quality evaluation service on domestic abuse, sexual abuse, online risk, social migration, youth justice and youth unemployment.

SISER adopts a cross-disciplinary approach and works with national governments, local authorities, charities and private sector companies. We offer substantial research experience, cutting-edge expertise, a focus on delivering high impact findings which make a difference, and a passion for designing robust, efficient solutions. Our research plays a vital role in our University's aim to make a big impact on our community, discovering new insights and potentially reaching world-changing conclusions. We closely work with our external partners to deliver the compelling research methodologies and robust evaluations.

Survivors in Transition (SiT)



SiT is a registered Charitable Incorporated Organisation, founded in 2009 by Fiona Ellis and Clare Wilson, as a result of their frustration at the lack of specialist services available for adult survivors of child sexual abuse (CSA) in Suffolk. SiT supports both male and female adult survivors of CSA, violence and exploitation, delivering an individual, innovative approach for survivors, providing a holistic service through which survivors are empowered to take control of their own lives. This is facilitated through information, advice, guidance, and referrals to other specialist organisations, as well as practical and emotional support facilitated through individual or group therapy, and peer support sessions, delivered by 26 volunteers, sub contracted therapists, two full-time and three part-time paid staff.

SiT's work continues to increase annually, particularly impacted by the Savile and subsequent high-profile CSA cases that have been exposed over recent years. Increasingly, survivors now feel able to disclose their sexual abuse knowing they are believable. And so SiT is supporting an increasing number of adult survivors of CSA, striving to provide access to the organisation without lengthy waiting lists, while working within a three-phase approach to dealing with trauma (stabilisation, trauma therapy and reintegration). Feedback from survivors accessing the service and completing interventions is overwhelmingly positive and 94 per cent of service users rate the service they receive as "excellent".

Research suggests the most effective support for adult survivors of CSA is within an open, relational context with a trusted adult, over a sustained period, providing survivors with the opportunity to counterbalance the power/influence of their perpetrator by being asked about their abuse. Furthermore, services should be within safe settings that provide the opportunity for counselling/talking therapy, interviews, and information/prevention sessions without judgement. SiT replicates current guidelines available on the most effective intervention/support for adult survivors of CSA,¹ therefore demonstrating a model of best practice supporting adult survivors of CSA.

¹ Blue Knot Foundation Best Practice Guidelines <https://www.blueknot.org.au/Workers-Practitioners/For-Health-Professionals/Resources-for-Health-Professionals>.

Executive Summary

This report is based on a collaborative qualitative research study conducted in partnership between the University of Suffolk and Survivors in Transition (SiT) between January and May 2018.

The focus of this study was initially broadly based on the main findings from the Focus on Survivors national online survey (see Smith et al., 2015)² which identified that the satisfaction with services for adult survivors of childhood sexual abuse (referred to as 'survivors' throughout this report) was closely related to basic qualities in the way services treated survivors, namely, feeling listened to, believed and respected. The study based on the online survey concluded that 'poor service can have a long-term impact and represent a barrier to support for survivors. In contrast, a good service response can result in survivors coming to a point of recovery or resolution sooner in their lives' (Smith et al., 2015: p. 4).

Following on from these findings in this under-researched area, this study was qualitative in nature, based on in-depth life biography style interviews with 28 adult survivors of child sexual abuse who volunteered to share their experiences of support services. This approach facilitated a deeper understanding of survivors' experiences on the path to effective support:

1. To gain deeper understanding of survivors' experiences of disclosure
2. To gain deeper understanding of pathways and support services survivors accessed
3. To provide the opportunity for adult survivors of CSA to consider what support had been effective for them and recommend how support services can be improved.

The methodology for this study was purposefully designed from the outset to be as collaborative as possible and to embed the involvement of service users throughout the research process. To this end, a Q-sort of the main findings from the 2015 Smith et al. study gave valuable insight as to what survivors identified as the main priorities for this more in-depth qualitative study. The results and

priorities from the Q-sort were then used to inform the focus and basis for the interview questions. The open-ended interview questions were further developed with the guidance of the Service User Group at SiT and formulated to allow the participants to discuss their experiences within their own terms of reference at their own pace and to talk about what was important to them.

The questions were piloted in January 2018 as one-to-one interviews conducted with seven survivors at SiT. The purpose of the pilot study enabled the research team to verify the suitability and sustainability of the questions for a larger qualitative study and for participants to provide additional feedback on the questions and process.

The wider study was undertaken between February and May 2018 with 28 survivors. The interviews, some of the interviews lasted over three hours, yielded rich, detailed descriptions of survivors trying to access help and support and their experiences of services. The study aimed to develop a deeper understanding of each survivor's experiences of:

- disclosure
- accessing services
- the support they had received
- what they felt 'worked' in terms of effective support and good practice
- and how survivors consider support services can be improved.

The findings are presented in such a way as to follow the dominant trajectory of the 28 survivors' narratives who volunteered to share their experiences with us. It starts with their disclosure journeys and considers the

² Smith, N., Dogaru, C. & Ellis, F. (2015). Hear me, Believe me, Respect me: a survey of adult survivors of childhood sexual abuse and their experiences of support services. University Campus Suffolk and Survivors in Transition.

barriers to disclosure and impact of delayed disclosure, before documenting the responses they received to their disclosure(s) and the consequences of poorly supported disclosures, which often resulted in barriers to seeking and accessing effective help. The over reliance on medication and the limitations of time-limited interventions are highlighted, as well as the dearth of available specialist support services. The findings suggest that specialist support which is available is often poorly signposted by professionals and, as a result, survivors battle for years, even decades with mental health issues as a direct consequence of delayed disclosure and inappropriate service provision.

This report finally documents 'what works' in effective help and support for survivors of CSA; their reasons for seeking help, and the importance of being listened to, believed and respected throughout their journey towards recovery.

The survivors' accounts reveal the importance of allowing survivors to engage with support services on their own terms, without a predetermined time period and within a safe, non-judgemental and inclusive therapeutic context. Their narratives evidence the positive and lasting impact of safe opportunities for survivors to engage with past trauma, to build trusting relationships with services, staff and therapists, to equip them with the necessary skills that can empower them take to control of their lives.

Key findings

All the survivors in our study indicated that delayed disclosure (the long duration of time between disclosure and engagement in specialist support services for adult survivors of CSA) resulted in the emergence of complex issues related to the experience of abuse, which had a detrimental impact on their mental health.

Most participants indicated that their first engagement with support services after disclosure was with statutory services, predominantly with their General Practitioner and emergency response services.

Participants indicated that the primary focus was on the mental health issues associated with survivors' experiences of CSA. Participants cited that these support services neglected to address the survivor's experience of sexual abuse in childhood directly, failing to ask pertinent questions which would have assisted disclosure of CSA.

All participants' narratives indicated that poor experiences with statutory services had acted as barriers to and delayed engagement with future support services.

Poor experiences of disclosure(s) and not feeling listened to, believed and respected by support services had acted as barriers to future support services.

Most participants described the process of self-referral, often following a particularly difficult period as the predominant route into effective services, finding organisations through self-exploration.

Participants specified that voluntary organisations had often improved on previous negative experiences, providing empathetic understanding and a gateway to other voluntary support services. They acknowledged the positive impact that voluntary/charitable organisations had in their aims to provide a safe environment for survivors to be listened to and believed, without shame and guilt.

The participants described how mental health statutory services had only offered/provided short term intervention at times of crisis, focusing principally on the treatment/diagnosis of the participant's mental health, and often lacked an understanding of the long-term trauma experienced by adult survivors of CSA.

A number of participants indicated that the comorbid mental health issues suffered by survivors of CSA (such as, post-traumatic stress disorder, depression, anxiety and a range of personality disorders) were recognised by health professionals as beyond the remit of support available within statutory settings.

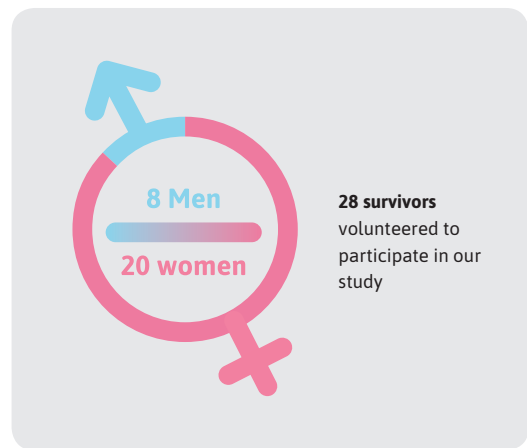
The survivors reported feelings of gratitude for the support and personalised approach to intervention provided by specialist support provided by voluntary/charitable organisations, often citing that they believed their lives had been saved by these organisations.

The study suggests that there is a need for better information and greater access to multi agency staff, better local knowledge, with better education and training.

Introduction

It is well acknowledged that ‘victims of childhood sexual abuse carry the experience of abuse into adulthood’². This report considers the support available to adults who have experienced child sexual abuse (CSA) from their perspective and in their words. It examines their disclosure journeys and the support they received as a result of their disclosure(s).

This report explores the missed opportunities by service providers to offer effective support and how poor experiences with service providers can result in barriers to further help seeking by survivors. The participants’ accounts detail how services could have responded better and what differences this could have made, as well as their suggestions for a whole system overhaul to ensure future generations get the support they need when they need it. For these survivors, their biographies highlight missed opportunities, but also illustrate what worked for them in starting their journey towards effective support and more fulfilled lives.



1.1 Current Context

The findings presented in this report are based on a collaborative, qualitative research study undertaken in partnership with the University of Suffolk and Survivors in Transition (SiT). The research findings are drawn from 28 one-to-one interviews with adult survivors of CSA about their previous and current experiences of disclosure, services and support, together with their opinions on how to improve support services.

Although public awareness is cumulative regarding the veracities of CSA, much of that awareness has stemmed from high profile cases of CSA exposed in the media. Despite improved awareness, survivors report experiencing considerable stigma attached to the disclosure of their CSA and carrying the burden of guilt and shame.

The World Health Organisation (WHO) defines child sexual abuse (CSA) as ‘the involvement of a child in sexual activity that he or she does not fully comprehend and is unable to give informed consent to’³. It is widely accepted that 1 in 4 women and 1 in 6 men have been sexually abused before the age of eighteen⁴. Radford et al. (2011) reported that 24.1% of young adults experienced sexual abuse in childhood. According to the ONS (2016) women were 4 times as likely as men to be a survivor of such abuse during childhood⁵ (11% compared with 3%⁶).



² Tener, D. Murphy, S. B. (2015) Adult Disclosure of Child Sexual Abuse: A literature Review. Trauma, Violence and Abuse, 16 (4) p. 391.

³ World Health Organisation (1999) report of the consultation on child abuse prevention 29-31 March 1999. WHO: Geneva.

⁴ Smith, N., Dogaru, C. & Ellis, F. (2015). Hear me, Believe me. Respect me: a survey of adult survivors of childhood sexual abuse and their experiences of support services. University Campus Suffolk and Survivors in Transition

⁵ Radford, L.; Corral, S.; Bradley, C.; Fischer, H.; Basset, C.; Howart, N. and Collishaw, S. (2011) Child abuse and neglect in the UK today. NSPCC

⁶ Office for National Statistics (2016). Abuse during childhood: Findings from the Crime Survey for England and Wales, year ending March 2016

I'll be a **survivor** for the rest of my life.

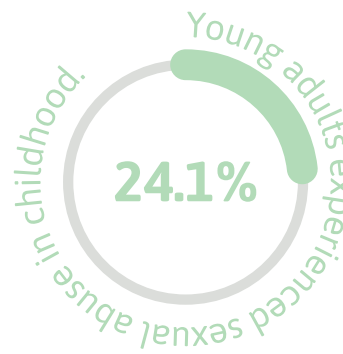


It just happens everywhere. *What concerns me is that it was me, my child, then my grandchild. That's three generations without any help. Nothing.*

Maeve
.....

This results in many survivors remaining silent about their CSA for years, even decades⁷, and waiting until adulthood to disclose,^{8,9} if at all¹⁰. Current research acknowledges that delayed disclosure without appropriate support can have a detrimental impact on survivors' physical, social, and mental health¹¹. This can lead to severe long-term mental health problems such as depression, PTSD, self-harm, anxiety disorders and addictions, and increased risk of re-victimisation¹², which certainly dominated the narratives of our participants¹³.

Research suggests that there are many barriers to CSA disclosure, barriers from within, barriers relative to others and barriers relative to the social world¹⁴. Currently, barriers to disclosure offset facilitators of appropriate support services for adult survivors of CSA. Studies suggest that disclosure is an interactive, complex, diverse, and individual experience for survivors of CSA.



Radford et al. (2011) reported that 24.1% of young adults experienced sexual abuse in childhood.

Support services are most effective when they provide straightforward, opportune access to supportive therapeutic resources, facilitating a relational context such as counselling.^{15,16}

This research was, therefore, developed to gain a deeper understanding of survivors' personal experiences of services, both statutory and non-statutory, and to contribute to the evidence base of the adequacy and efficacy of service provision, to identify aspects of good practice on which to build.



*We think about it all the time, **we live it every day.** It's just me alone.*

Dave
.....

⁷ Dworkin, E. R., Ulman, S. E., Stapperberk, C. & Brill, C. D. (2017). Proximal relationships between support and PDST symptom severity: A daily diary of sexual assault survivors. Department of Psychiatric and Behavioural Studies. University of Washington: Seattle. USA.

⁸ Gagnier, C & Colin-Vézina, D. (2014). The Disclosure Experiences of Male Child Sexual Abuse Survivors. *Journal of Child Sexual Abuse*, Vol 25, (2), 221-241.

⁹ Easton, S. D. (2012). The disclosure process for men with histories of sexual abuse. *Clinical Social Work Journal* 12, 1-12.

¹⁰ Office for National Statistics (2016). Abuse during childhood: Findings from the Crime Survey for England and Wales, year ending March 2016.

¹¹ Fisher, C.; Goldsmith, A.; Hurcombe, R. & Soares, C. (2017) The impacts of child sexual abuse: A rapid evidence assessment. IICSA.

¹² McElvaney, R (2013). Disclosure of Child Sexual Abuse: Delays, Non-disclosure, and Partial Disclosure. What the Research Tells Us and Implications for Practise. *Child Abuse Review* 24, (3) 159-169, & Fisher, C.; Goldsmith, A.; Hurcombe, R. and Soares, C. (2017) The impacts of child sexual abuse: A rapid evidence assessment IICSA.

¹³ Macintosh, H. B., Fletcher, K & Collin-Vézina, D. (2016). "As Time Went On, I Just Forgot About It": Thematic Analysis of Childhood Spontaneous Disclosures of Recovered Memories of Childhood Sexual Abuse. *Journal of Child Sexual Abuse*. Vol. 25, (1), 56-72.

¹⁴ Alaggia, R., Colin-Vézina, D. & Lateef, R. (2017). Facilitators and Barriers to Childhood Sexual Abuse Disclosures: A Research Update (2000-2016). *Trauma, Violence and Abuse*, & Allnock, D. & Miller, P. (2013). No one noticed, no one heard: a study of disclosures of childhood sexual abuse. NSPCC.

¹⁵ Tenner, D. & Murphy, S. B. (2015). Adult Disclosure of Child Sexual Abuse. *Trauma, Violence, & Abuse*.

¹⁶ Alaggia, e et al. (2017).

2. Overview of the research

2.1 Research aims and methodological approach

1. To gain deeper understanding of survivors' experiences of disclosure
2. To gain deeper understanding of pathways and support services survivors accessed
3. To provide the opportunity for adult survivors of CSA to consider what support had been effective for them and recommend how support services can be improved.

Q Methodology¹⁷ is now well-established in a very wide variety of academic disciplines to gather the viewpoints of a large group in order to provide researchers with a systematic means for examining human subjectivity.

Fifteen statements derived from the key findings from Smith et al.'s (2015) report were provided to nine service users, eight support staff and seven therapists working with survivors, who were all asked to rank the statements in order of priority. Once in a priority order, each statement was scored +7 for most important to -7 for least important, with a 0 assigned to the middle statement. The scores for each individual participant were added together to identify which statements had scored the highest in the group. Interestingly, support staff, therapists and survivors selected the same six priorities.

The most important findings from the national survey that the participants in the Q-sort highlighted were:

80 per cent of survivors were not asked if they had been abused. Instead, they made their disclosures without being asked, which would have meant taking the step to bring up the subject themselves and reveal traumatic experiences of sexual abuse

less than half of those who used social services or A&E and hospital services felt that they had been listened to, believed and respected

poor service experience can represent a barrier to further service use

a key barrier to getting help was overcoming the difficulty of talking about experiences of being sexually abused

less than a third of respondents agreed that professionals and services provided the information they needed, and well over half said that they found the information they needed on-line. Most respondents (over three-quarters) did not find it easy to find the information they needed

the most helpful support are services which had listened to, believed and respected them.

There are many different research strategies based on interrelated epistemological, ontological and practical foundations, and it is essential in devising a robust research strategy that the research methods effectively meet the aims and objectives of the study.

'The life-course perspective has long been recommended as a critical lens for the study of child abuse¹⁸. This research set out to examine adult survivors of CSA's experiences of support services and, as such, we adopted the use of interviews to produce qualitative data. Our methodological approach was appropriate to meet the objectives of the study and other methods may not have

¹⁷ McKeown, B. and Thomas, D. (2013). Q Methodology (2nd. Edn). London: Sage

¹⁸ Alaggia et al (2017)

provided the rich insights into the survivors' experiences presented in this report. Throughout the study, we were keen to address the traditional imbalances of power and strived to ensure that the survivors' voices remained at the centre of the research strategy, its design and in the way that the findings of the study are reported.

While opportunity sampling is sometimes viewed as a less robust form of sample selection (than, for example, a random sample strategy more commonly used in surveys), it is widely accepted in the research community as being employed by social researchers studying hard-to-access groups. Although concerns may be raised from a positivist perspective over the small sample size, and the difficulty in replicating and generalising from the study; these are common disadvantages associated with qualitative research. The limitations of the study are acknowledged, but many of the findings of this study closely reflect findings of wider previously published research on adult survivors of CSA¹⁹ and offer an in-depth explanatory account from the survivors' perspectives.

There can be very positive outcomes in participating in sensitive research, as participants can talk about²⁰ issues and concerns that they may not otherwise have had the opportunity to talk about. This was certainly reflected in the rich nature of the descriptions in the data obtained in our study.

28 survivors of CSA volunteered to participate in our study. Eight men and 20 women, all of whom were either currently accessing support or who had recently done so from specialist support charity, Survivors in Transition, based in Suffolk. It is important to note that many had not lived in Suffolk all their lives, nor in some cases for very long. Thus, any references made to other services – GPs, mental health services, social care or the police are not necessarily geographically local or specific to Suffolk.

We did not seek to verify personal information from our voluntary participants, thus the sample is not broken down by age nor ethnicity.

2.2 Ethical considerations

'Ethics are a set of moral principles that aim to prevent researchers from harming those they research'²¹ and ethical approval for the research was gained from the Research Ethics Committee of the University of Suffolk prior to the study taking place. Two common issues within the ethical decision-making framework are informed consent and privacy. So, in order to be mindful of ethical requirements and meet the principles of high quality research, written information about the research, its aims, design and process were available to all participants. Importantly, all 28 survivors participated on a voluntary basis, knowing that they could withdraw from the study if they wished to.

The participants' names and identities have been rendered anonymous in the report, although the quotes taken from the interviews have been given pseudonyms. The research team had up-to-date Disclosure and Barring Service certificates, and are highly experienced in conducting research interviews and in researching sensitive topics. We strived to ensure ethical sensitivity and a participant-centred approach throughout the research process and were careful not to jeopardise the survivors' well-being.

This research project complied with both the British Sociological Association and the British Psychological Society's guidelines, and adhered to the guidelines set out by the UK Research Integrity Office's (2009)²² code of practice for research, and the Singapore Statement on Research Integrity,²³ based upon the principles of:

- Honesty in all aspects of research
- Accountability in the conduct of research
- Professional courtesy and fairness in working with others
- Good stewardship of research on behalf of others.

¹⁹ Smith et al. (2015).

²⁰ Dickson-Swift, V., James, E. L. and Laimputtong, P. (2008). *Undertaking Sensitive Research in the Health and Social Sciences*, Cambridge Medicine: Cambridge

²¹ Dickson-Swift et al. (2008): p. 26

²² UK Research Integrity Office (2009). *Code of Practice for Research: promoting good practice and preventing misconduct*. Available from <http://www.ukrio.org/publications/>

²³ Singapore Statement on Research Integrity, available to download from <http://www.wcri2010.org>

2.3 Report plan

The report outlines the findings from the in-depth qualitative interviews based on the key themes to emerge from the analysis of the interview data. The sections broadly follow the trajectory of the survivors' narratives.

Chapter 3: The burden of disclosure - documents how survivors attempted to, and in some cases did, disclose their abuse and the responses they received from family and professionals when they did so

Chapter 4: Experiences of services - explores how subsequent response and ineffective or inappropriate support often manifested as a barrier to further help seeking and making further disclosures

Chapter 5: What works - identifies what had effectively helped survivors in their recovery journeys

Chapter 6: Conclusions and recommendations - draws together the main findings from the study and makes some recommendations for improving service delivery for adult survivors of CSA.

Our study considers the disclosure journeys of 28 adult survivors over their lifespan, from childhood through adulthood and, for many, into late adulthood. We did not specifically ask the survivors about the specific nature and circumstances of their abuse. We recognise that 'Survivors Voices' narratives undertaken by One in Four (2015) captured the details of 21 survivors' experiences of sexual abuse in the family environment, although, in some narratives, these details were included as the survivors chose to share them with us.

3. The burden of disclosure

'Disclosure enables access to support and protection, both therapeutically and legally'.²⁴ Identified by the survivors in the Q-sort as important was a key finding from the Smith et al. (2015) survey, that 80 per cent of survivors were not asked if they had been abused. Instead, they made their disclosures without being asked, which meant taking the step to bring up the subject themselves and reveal traumatic experiences of sexual abuse.

This section of the report outlines the disclosure journeys of survivors. It documents the **contexts and circumstances of their disclosures, the recipients of the disclosures, accounts of the responses they received, what caused delayed disclosure and time taken from making a disclosure to getting support.**



*It was stark, really hard. I disclosed to everyone, to be honest. I was so ill. **There was no support for the fact I had been sexually abused at all, just for the depression.** I was discharged. I had a community support worker. I disclosed to them but nobody seemed interested.*

Jill
.....

3.1 Context

Jill's account above exemplifies the complexities of many accounts we heard about the survivors' disclosure journeys. While the nature and circumstances were unique to each survivor, common themes and similarities emerged from the analysis of the data, which catalogued many of the difficulties around disclosure, including a host of missed opportunities, a lack of empathy and understanding from those they disclosed to and the detrimental impact that had on the survivors' well-being.

It was clear from the data that survivors frequently attempted disclosure at points of crisis. Many described the manifestation of flashbacks, nightmares and panic

attacks, often combined with a stressful life event, which had prompted a sense of immediacy to access appropriate support and disclose their abuse, many for the first time. Echoing the other survivors' accounts, Maxine told us:



*Life was unbearable. I've been on anti-depressants for 22 years. They don't work, I knew there was something very wrong with me. **I just needed help.***

Maxine
.....

Each disclosure journey was unique. The survey undertaken by Smith et al. (2015) identified that the average duration of abuse was seven years, with the length of time between the abuse starting and disclosure an average of 16 years.



The average time span for disclosure from the start of abuse to disclosure in **our study was much longer – over 27.5 years.** However, the youngest four survivors (aged between 19-24 years) revealed they had disclosed between seven and 11 years after the onset of abuse.

²⁴ Morrison, S.E.; Bruce, C. and Wilson, S. (2018) Children's Disclosure of Sexual Abuse: A Systematic Review of Qualitative, Research Exploring Barrier and Facilitators. *Journal of Child Sexual Abuse*, 27 (2) 176194.

Childhood

According to the Office of the Children's Commissioner, only 1 out of 8 children who have experienced CSA come to the attention of UK statutory agencies²⁵. Disclosures are often made a long time after sexual abuse begins and disclosure rates in childhood are low²⁶:



*All the time I was trying to cover it all up. **I couldn't tell anyone.***

Emily
.....

Six survivors told us that their initial attempts to disclose their sexual abuse were in childhood. Wendy, for example, described her early attempt to disclose her abuse:



I was probably nine years old. I didn't understand that it was abuse at that time. *I thought I was dying. It was my brother that had abused me. I thought I was dying and so I had a bath and just wanted to go to bed. I woke up the next morning. I wasn't going to school. My mother had mental health problems so, I could get around it. I sat all morning waiting to get her attention... it must have been late morning and she looked at me. I meant to say my brother had made me sick but instead I said she'd made me sick. So it all came out wrong.*

Wendy
.....

13 participants identified that they lived with their abusers as children, or that their abusers were close by, making disclosure difficult. Alice described how after her disclosure, aged 12, she continued to experience recurring denial by her family which prevented her from further attempts to disclose:



*That's your Mum, someone you care about a lot... but, my Dad was there, and he heard that but, that was kept quiet. No one speaks about that side: my Dad doesn't, my mum doesn't know. **I talk to my Mum and think, do I have the courage to actually say to you that partly the reason the way I am now is because of the way she was.*** *It's just arguments and it's hard because, I am from a broken family; my family is broken, as broken as what you can get.*

Alice
.....

Two of the youngest participants told us that their attempts at disclosure led to further re-victimisation, as they were sexually assaulted by someone they deemed to be a trusted adult:



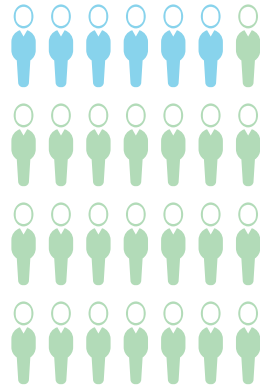
When I told that teacher he laughed and took advantage, *another degree of abuse. It felt like I had nowhere to go. School wasn't safe, home wasn't safe.*

Clare
.....

²⁵ Office of the Children's Commissioner (2015) Protecting children from harm: A critical assessment of child sexual abuse in the family network in England and priorities for action.

²⁶ Allnock, D. and Miller, P. (2013). No one noticed, no one heard. NSPCC available from <https://www.nspcc.org.uk/globalassets/documents/research-reports/no-one-noticed-no-one-heard-report.pdf>.

Six participants told us that there was no opportunity to disclose, which furthered the longevity of disclosure and increased the feeling of denial and trivialisation.



Allnock and Miller's (2017: 30) study found 'that the young people also described numerous signs and signals which indicated abuse but which were not acknowledged'.

Similarly, the survivors in our study believed that the signs of their CSA were evident to both family and wider society, describing a variety of signals and behaviours which should have been addressed.



I was having constant panic attacks. I didn't realise they were panic attacks at the time, I was only 14 or 15 at the time. So I just thought it was me, being me. I can't put it into words, it was me alone.

Dave
.....

Although many children do not disclose abuse in childhood, research has shown that the signs and symptoms of abuse were there but 'no one noticed and no one asked'²⁷.

Mary's narrative exemplifies other survivors' experiences as she describes the ways in which she felt her behaviour should have been noticed as **red flags**, saying:



For me looking back there's certain ways I was presenting and behaving that would and should have raised red flags with professionals around me, but they didn't. I don't know whether it's because they didn't want to, or they didn't see it or weren't particularly interested... but I think if I saw what was going on and how I was presenting I would have been really concerned about what was going on. It wasn't that long ago, just over 10 years ago.

Mary
.....

Adulthood

'Disclosing CSA in childhood may involve barriers and facilitators that are qualitatively different than those experienced by adults'.²⁸ Disclosure to statutory support services as adults for survivors was often prompted by a stressful life event including mental health issues, pregnancy, surgical interventions, a desire to protect future victims of CSA, or as a result of police intervention due to an ongoing investigation.

As outlined above, although young people who are sexually abused do not often disclose their abuse, many would have liked someone to have noticed the signs and to have asked them²⁹. Reflecting these findings from research with young people, the adult survivors in our qualitative study described how, over decades, they had been presenting with symptoms of anxiety and depression but said that they were never asked the cause of their presenting problems.

²⁷ Allnock and Miller (2013).

²⁸ Lemaigre, C.; Taylor, E. P. and Gittoes, C. (2017) barriers and facilitators to disclosing sexual abuse in childhood and adolescence: A systematic review. *Child Abuse and Neglect*, 70, p. 40.

²⁹ Allnock, D. & Miller, P. (2013).

Jill, for example, described her engagements with a variety of support services over a number of decades, and how they repeatedly ignored her experiences of CSA and failed to respond to her repeated disclosures:



*I think community support workers, consultants; they don't seem to understand if you bring it up. They just look at me as well, right. **It doesn't seem to click with any of them. They don't even ask me what I'm talking about.***

Jill
.....

'Recent research has highlighted the need for children to be asked direct questions to facilitate their disclosure'³⁰.

Tom's story provides a frank example of a missed opportunity to disclose. His interaction with emergency services after a serious self-harm incident starkly highlights the importance of asking pertinent questions and also illustrates how missed opportunities result in a barrier to accessing effective help:



***I tried to cut him out with a scalpel; I took the scalpel to my genitals.** When the paramedic turned up he said, "What you done that for? Don't you think you're being selfish?" He didn't think, 'come on, what's going on here?' He didn't ask. If he had I might have seen the psychosexual counsellor four years earlier. You just think, why bother?*

Tom
.....

3.2 Responses to disclosure

19 of the 28 survivors we interviewed initially disclosed to a close family member, namely their mother or in some cases grandmother.



Echoing Allnock and Miller's (2017) study with young people, some adult survivors in our study described negative experiences of disclosing to their mothers as characterised by disbelief, accusations of lying or ignoring the disclosure. As revealed later in this report, these negative experiences of disclosing acted as a barrier to further disclosures, often for many years, as Emily's and Maxine's accounts exemplify:



The abuse happened for about eight and a half years from the age of just before my thirteenth birthday up until I left home at 21.

After about six months I went to my Mum. This is going back to the 70s, when things like this weren't talked about and so I told her – this was my stepfather who was abusing me. And my Mum didn't disbelieve me but she said she would ask him and he told her a story and so she believed his story above mine. So I realised I wasn't gonna get anywhere.

Emily
.....

³⁰ McElvaney, R. (2015) Disclosure of Child Sexual Abuse: delays, Non-disclosure and Partial Disclosure. What the Research Tells Us and Implications for Practice. Child Abuse Review, 24 p. 164.



*I just blurted it out one day., **I was fed up of the shadow of him in the background all the time, so I told her. She called me a lying little bitch and gave me a slap.** She did ask him, he admitted it to her. She said he laughed about it. She still carried on seeing him so, at that point I didn't bother disclosing to anyone else after that.*

Maxine
.....

Nearly half - 13 survivors recognised that the very negative responses to their disclosures from close family members – either normalisation or denial – were consequences of an intergenerational cycle of abuse within their families and strongly linked to the family members' own experiences of abuse.



*When my Mum was 14 she'd got expelled from school, grammar school. I found that in her notes. I think there's a likelihood she was pregnant and also her memories of my grandfather and why he kept taking her in the other room. **So I think that's what her issues were; her father was abusing her.***

Wendy
.....

3.3 Denied and delayed disclosures

In considering the reasons behind delayed disclosure, the concepts of stigma and shame dominate the accounts. Research to date suggests that 'many victims continue to suffer in silence as evidenced by the high numbers of delayed disclosure'³¹. Beth, for example, described how she had delayed disclosure and access to support for 33 years, recognising from her initial attempts to disclose that childhood sexual abuse is a taboo subject:



***It's a taboo subject. Nobody wants to talk about it if it has not happened to them.** 33 years I've lived with all of this. It all comes out in the open and sinks back in again.*

Beth
.....

Whilst recognising the benefits of increased awareness and recent media reporting of CSA, the survivors were clear that shame and stigma create a barrier to disclosure:



*I think it's vastly improved in the last few years, with people reporting, getting cases brought back up. Which is great from a social perspective, that people can get help and people will believe you., **But I think there's still quite a lot of stigma around it. Until society can overcome that stigma, people will always be unwilling to disclose.***

Vicky
.....

The majority of participants' narratives suggested that while social stigma prevailed, disclosures for adult survivors of CSA would remain elusive without access to appropriate support services.

Furthermore, the participants documented numerous occasions where they had experienced misconceptions

and an innate lack of understanding of the psychological trauma of CSA and how this impacted on their lives.

The accounts reveal frequent instances of support services ending abruptly around or close to disclosure. Clare specifically described how she had attempted to disclose to a mental health professional with whom she had engaged over a number of months and had established trust, when it had ended abruptly just at the time when she felt she wanted to disclose:



*She said, “**I need to lower my caseload, so you’re being discharged**”, I said, “Could I tell you something?”, and she said, “Don’t tell me anything, I don’t want to know, we’re discharging.” So I just left it.*

Clare
.....

Survivors described how poor responses to their disclosures and earlier help-seeking attempts prevented them from continuing to access help and support.



All 28 survivors talked about the complexities of delayed disclosure, and their narratives reveal a catalogue of missed opportunities by professionals, often spanning decades, to ask pertinent questions in order to facilitate their disclosure, which would have enabled them to access more appropriate support of their presenting psychological symptoms earlier.

Neil told us about his emotional suffering, incurred as a result of delayed disclosure, and he described how he had retained the identities of his perpetrators throughout his life:



*I just kept shut up about it. It was funny; it’s in your head, it’s there all that time in your head. **I’ve had them with me in my head, their names and everything, since I was at school.** They’ve probably moved now. I’ve never forgotten.*

Neil
.....

4. Service provision

'Timely access to supportive and therapeutic resources for child sexual abuse can mitigate the risk to the health and mental well-being of children, youth, and adults'³². Many of the survivors interviewed spoke of how bad things had got before they were offered any assistance at all:



*You have to be in **such a bad place to get help.***

Tom
.....

The 2015 research highlighted that survivors use a range of support services and identified how and when services were accessed. GPs, mental health and counselling services were most commonly used, with a half or more of survivors stating that they had used these services as a result of sexual abuse in childhood. The next most commonly used services included voluntary sector sexual abuse and rape support services and psychotherapy services, followed by the police, the Samaritans, and A&E and secondary health services.³³

Survivors used a range of services over a long period of time: on average, between four and five services over a ten-year span between the first service accessed and the most recent service use. Satisfaction with services was closely related to whether survivors felt listened to, believed and respected. In the survey, there was a sharp contrast between satisfaction with statutory sector and voluntary and independent sector organisations. Among survivors who had used both sectors, over 70 per cent were more satisfied with voluntary sector services than with statutory services.



*You have to be at rock bottom to get help, which I was last year. **I wanted to die.***

Maxine
.....

It was apparent from the analysis of the survivors' narratives in this study that there was a distinctive, definitive pattern of accessing ineffectual services, either which were not only expensive, time consuming and sometimes altogether inappropriate, but, in the majority of cases, they worsened or prolonged existing symptoms such as anxiety, depression, self-harm and flashbacks. Often, participants described help-seeking as their last hope, identifying a desperate desire for effective specialist support; while some survivors had attempted suicide during this process.

All the participants in our study told us that the majority of their initial engagements with statutory support services were through a GP, which many survivors identified as a catalyst for other referrals to a variety of mental health professionals. Referrals and access to these types of support, however, was often not immediate.

³² Alaggia et al (2017).

³³ Smith et al (2015).

³⁴ London et al. (2005). Psychology, Public Policy, and Law Copyright 2005 by the American Psychological Association 2005, Vol. 11, No. 1, 194–226.

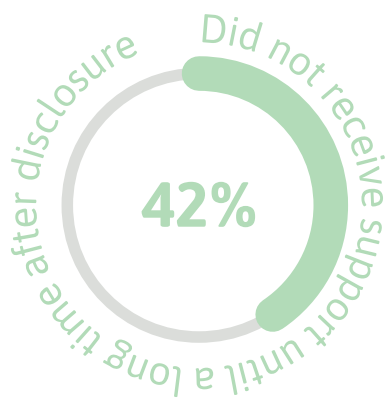
³⁵ Jonzon, E., & Lindblad, F. (2004). Disclosure, reactions, and social support: Findings from a sample of adult victims of child sexual abuse. *Child Maltreatment*, 9, 190–200. doi:10.1177/1077559504264263.

4.1 Access to services

There is a long delay between disclosure and accessing services. Previous research conducted in the early 2000s identified the gap between disclosure and accessing support services:

- London et al.'s literature review of disclosure³⁴ indicates that two thirds of adults who had been abused as children reported that they did not disclose the abuse during childhood, and the average delay between abuse onset and access to services through disclosure was 15 years
- Jonzon and Lindblad (2004)³⁵ reported that less than one third disclosed the abuse during childhood, and most of the survivors waited an average of 21 years until disclosing during adulthood.

Disappointingly, around 10 years later, our 2015 research established **that 42 per cent of survivors did not receive support until a long time after disclosure, on average, 12 years later.**



This demonstrates a lack of improvement in this rate and consistency in response over a period of time, and that it is still taking survivors a very long time to access services post disclosure.

It is interesting to note that the majority of research articles and published studies around CSA disclosure in adulthood are produced by Local Authority Safeguarding

Children or Adult Safeguarding Boards in relation to the response process and reporting elements framed in safeguarding, rather than what constitutes effective support, which our study explores further in Section 5.

GP's were seen as highly trusted professionals in survivor's journeys and 27 survivors in this study sought assistance from their GP and it is therefore not unusual that GPs were most commonly the first service survivors had contact with as a result of CSA (48 per cent of Smith et al.'s original study stated this was their 'first port of call' and the first 'service' used by survivors post disclosure).

Responses by GPs to the request for support were viewed both positively and negatively:



It's a mixed bag when it comes to GPs, I've had good and bad.

Kirsten

Whilst all the survivors in our study talked about their experiences of health professionals, less than half (only 10) survivors had had any contact with the police³⁶. Seven of them described their experiences as negative, which became a barrier to future contact with the police or engaging with the Criminal Justice System and access to appropriate support:



The police, they need to genuinely understand what it's like to be a survivor, what it's like living with these histories. It feels like they're obligated to report historic cases, but I don't feel like they took it seriously.

Kirsten

³⁶ Please note, this is not referring to any specific constabulary.

Referred into statutory mental health services

The 27 survivors who had sought help from their GP described a diverse assortment of referrals and signposting into a broad range of statutory mental health services, including primary and secondary, Improving Access to Psychological Therapy (IAPT) crisis, community and in-patient services over a long period of time. Involvement with mental health services was often described as lengthy, with survivors referring to a 'revolving door' within these services across the course of many years.



*I was self-harming a lot, not eating, making myself sick, all self-destructive stuff. **Over a period of six years I'd had seven different mental health professionals.** I had at least four to five changes in just one year...*

Clare
.....



*I've come away and thought, that's a waste of time. **I've been seeing a psychiatrist for 10 years, I've had 10, roughly one a year,** I think the most I've seen one psychiatrist is four times. You know, you can't build up a rapport with them.*

Tom
.....

In the 2015 research, 88 per cent of survivors used at least one of the services listed in the questionnaire, and, on average, respondents used between four and five services. The average time span of using services was over 10 years between the first service accessed and the most recent new service.

The 28 survivors we interviewed focused their discussions on service access on statutory mental health services, often referring to the time it took and barriers to accessing the services in the first place. They also described in thematic detail why they regarded these services as ineffective,

stating that they lacked care and empathy, focused on the symptoms not the cause, were time-limited and lacked specialist knowledge.

Lack of empathy

25 of the survivors' accounts detailed disclosures made to professionals in statutory settings. However, they identified an unwillingness by many professionals to acknowledge the disclosure with empathy.

The survivors' accounts were therefore littered with examples of being systematically let down and feeling that they had been failed by professionals. Kim described how her disclosure of her CSA was prompted by the need to protect further victims from her perpetrator. Yet even though the professional was aware of the severity of her symptoms of psychological trauma as a result of her CSA, he had discharged her after one session, failing to provide any appropriate support.

All the survivors who spoke to us described numerous encounters with support services that demonstrated an innate lack of empathetic understanding, professional knowledge and expertise in how best to provide appropriate support for adult survivors of CSA. They described a lack of continuity in their care and how, as a result, the inherent distrust they felt as adult survivors of CSA was magnified. Dave, for example, cited his interaction with a mental health professional, describing how, when he had disclosed his CSA, his disclosure was met without empathy and understanding and trivialised his experiences:



*I was referred to a counsellor by my GP. **I spoke to the counsellor about the sexual abuse, then he said, "It was just two people experimenting".** That shocked me. I knew it wasn't right, it was just trivialised. I thought I was making a mountain out of a molehill. So I thought I was making too much of it. It was very difficult.*

Dave
.....

The lack of empathy identified was further associated with the continued longevity of delayed disclosure, subsequently perpetuating re-experiences of the CSA trauma. All the participants felt that as a result, they continued on a path towards a crisis.

Some survivors described how they had not felt listened to or cared for when accessing statutory mental health services, as the three quotes below exemplify:



*I just felt like **everyone was working from a script.***

Polly
.....



***With mental health you're not ever allowed an opinion. I don't feel heard.** A lady at mental health told me to sit down. She accused me of getting aggressive because I only asked what was going on. I wasn't rude. You're not allowed an opinion with them, or the doctors.*

Neil
.....



***Once my psychologist left no one else cared.** They were under-staffed and didn't have the time for me. It was everything, getting my name wrong... not really getting to know me that was the major part. I was just a number, not a person.*

Becky
.....

Treated the symptom, not the cause

The long-term effects of CSA are well documented and survivors in our study recognised on reflection that often their presenting 'symptoms', such as anxiety, depression, self-harm and eating disorders, had been treated and the underlying cause was never sought by professionals. Many felt that this had given rise to many missed opportunities to access effective services (as described in Section 3).



***When I saw the psychiatrist regularly, we never spoke about abuse; it was never brought up. It was clinical,** focused on how much I was eating, where I was cutting and whether that cut was clean.*

Clare
.....

Six of the 28 survivors revealed their experiences at residential in-patient mental health units. All six identified the fact that this type of intervention had repeatedly missed opportunities, over decades, to recognise or validate their disclosures, as well as failing to provide effective support.



*I didn't say I'd been sexually abused;; I literally screamed it because I'd cried for literally two days. **48 hours I was crying, not sleeping, nothing, just crying and I screamed this out.** It took an awful lot, winding myself up to do it. I screamed out, "He touched me, he did things to me!" – two or three sentences. After that they were like "calm down, let's give you some Diazepam".*

Cathy
.....

Time constraints

In the 2015 research, survivors criticised services that were time-limited and respondents felt strongly that the lack of sustained support was problematic. In our study, survivors reiterated this, as Chris' quote exemplifies:



10 minutes just isn't enough. *How can you talk about all this, in 10 minutes so? You just end up talking about how you're feeling on that day.*

Chris
.....

Emily and Wendy's accounts, for example, reflect the narratives of all 28 participants' descriptions of the limitations in accessing effective support, signifying the necessity of time when disclosing their experiences of abuse and in responding effectively to it (picked up in section 5):



*I was given six sessions... I didn't feel like I got anywhere. She didn't seem to be helping me, **she didn't understand. I felt like she had a checklist**, 'have you done this, have you tried that'. I thought you don't understand because if you did, you would know how difficult it was for me so. I thought we're just wasting each other's time. I went for the last session, [and] came away thinking I hadn't had any help at all, whatsoever.*

Emily
.....



In the NHS, the time frame [is] only six weeks. How can you feel listened to and believed? *You open up a can of worms and then you're left.*

Wendy
.....

Furthermore, long waiting lists and the constraints of limited six-week interventions were cited as reasons that survivors sought private alternatives:



I was told it would be months and months before I would get an appointment and even then, it would be only six sessions. So I decided to go private.

Kirsten
.....

Training/knowledge

The survivors we interviewed described two distinctive elements around specialist knowledge and training of professionals. Firstly, they recognised that not all professionals that they disclosed to could be expected to have specialist knowledge to deal with the effects of sexual abuse, but they expected them to be able to acknowledge, validate and refer on appropriately. Secondly, these survivors felt strongly that when professionals were out of their depth, they should be able to acknowledge that and refer on to more appropriate help.



*A few weeks into [counselling service] I would have thought they would have known better, **which brings it down to the fact that people don't have an understanding of childhood sexual abuse.** Even professionals who should know and have understanding don't, although our expectation is that they should.*

Cathy
.....



I always felt the community support workers I have had aren't specialised enough in that area. I mean good to talk about my depression and what I was feeling on that day, but not to talk about how I was feeling or what I had experienced 30 years ago.

Jill
.....

An interesting point to emerge from our study was that the survivors we interviewed gave examples of poor and inadequate services provided by a range of interventions across agencies, individuals and services, statutory and private:



Well at first it was okay, but I think it was the fifth or sixth session and I started to talk about the abuse and ***the counsellor said, "I can't deal with this, I'm not qualified to deal with this".*** So that was another slap, really. That sort of put the brakes on things again because I felt awful I'd made her upset. So again I got a bad reaction.

Wendy
.....

Several survivors described feeling angry and resentful that they had spent lots of money accessing private therapy and, in three cases, survivors spoke of this being inadequate or unsafe:



I took myself to private counselling, paid an absolute fortune. I think on the sixth or seventh occasion of seeing her, ***I became aware that for me this was becoming incredibly dangerous; that I wasn't feeling any better, each time I was getting deeper and deeper into a blackness.***

Maeve
.....



The private counsellor, basically I was seeing him first but, ***he wasn't experienced enough in how to deal with complex PDST.*** So he opened up a big Pandora's box and he didn't know how to keep me safe and then that's when I took the overdose and then that's when the mental health team picked me up.

Maxine
.....

Survivors described how poor responses to their disclosures and earlier help seeking attempts prevented them from continuing to access help and support. Poor responses to disclosures of CSA were not limited to face-to-face experiences: both Tina and Polly talked about the negative experiences they had had after contacting national helplines:



I contacted [...] helpline and spoke to someone on the phone, and then I left it from 1992-2016 because it made me feel depressed and ***it was really hard to talk on the phone.***

Tina
.....



*One night I rang the [...] helpline. **They told me to have a bath and make a cup of tea. It's really hard to reach out to anyone and ask for help.** They don't realise you've already tried all that before you reach out for help.*

Polly

Similarly, Sarah, had accessed a generalised sexual assault support helpline only to be told that her CSA experiences were beyond their remit:



*I was desperate for help. **They told me my history was something they couldn't help me with.***

Sarah

4.2 Labelling & medicating

The survivors we interviewed all described the dominance of a clinical, medicalised focus in statutory service provision with the over-use of prescription drugs and diagnoses that further exacerbated their feelings isolation and of not being listened to. Their accounts resonate with a pattern of being labelled and medicated. Yet it was apparent from all the accounts that the survivors felt that labels were often unhelpful and masked the underlying cause (CSA) and that medication merely suppressed the symptoms of psychological trauma.



*The other thing I hate... is 'mental health' which is a real issue with me. I've been called mentally ill. **I'm not mentally ill! I was abused you know, this is the result of abuse. This is not me mentally ill.***

Cathy



*I've been on anti-depressants in the past but, they didn't know what had happened in my childhood; no one asked. They just said I'd be on them for the rest of my life. **But I don't think it's an illness. It made me feel really bad thinking I'd be ill all my life. I wanted counselling but they didn't seem interested.** It made me feel lonely. I got panic attacks, I wouldn't go out, so that didn't help.*

Tina

Poor mental health in adulthood as a direct consequence of CSA is common and well documented³⁷. It was clear from the accounts that the journey to diagnosis in itself was lengthy often taking years:

³⁷ Fisher et al. (2017).



*I got diagnosed six months ago with a personality disorder, anxiety and depression. Went back there three months ago and got diagnosed with PTSD. So, **to get a diagnosis it's taken about six years**, so a long time. I have been in and out of doctors saying, "I felt shit, help me, I don't know what's going on in my head" but no one bothered to get involved.*

Alice

Many of our respondents spoke about diagnosis of a range of mental health issues, including half of our participants (14) who had been diagnosed with generalised anxiety, 25 reported a diagnosis of depression and 14 identified that they had a diagnosis of either PTSD or a personality disorder.



***I query whether personality disorder should be labelled because actually everybody's different.** There's not a set personality; people have different coping mechanisms about experiences within life. It doesn't just happen overnight and then you suddenly have however many personalities. I don't think it's helpful to anyone to say to someone this is who you are, actually. That's not helping anyone. You need to look into the reasons why, especially as after diagnosis there's not really any support; you're just left.*

Mary

However, the labelling process further prevented the cause of the presenting symptoms being properly considered or appropriately responded to. Being diagnosed often took a

long time to happen but when it did, it was often sudden and without explanation.



*I was nineteen and a half before I got properly diagnosed. **That was a shock, especially when it happened in the space of two months.** I saw the psychiatrist and 15 minutes later I've got a diagnosis of emotionally unstable personality disorder.*

Alice

The diagnosis of a mental health condition also had wider impacts on personal, social and professional identities, as Sarah explained:



*You know it's a diagnosis. It probably is like I said to my care worker, when I go for a job, the type of work I have done and **they ask for my medical records and that gets put on... I'm screwed, no matter what people say. I would not be given a job, as I would have been without diagnosis.***

Sarah



*I've just muddled through for the last 10 years on medication. It's not solving the problem, just quietening it all down. **They drug you up and send you on your way.** It's just sticking a plaster over it all.*

Polly

I'll be a **survivor** for the rest of my life.

What is also stark in the accounts is that having battled for years to seek help and support, that, while a diagnosis provided some validation of their abuse, it often signified the end of support provided by statutory support services other than medication, illustrating how a focus on diagnosis often signified the end of intervention by statutory services.



*All they were interested in doing was getting me diagnosed, **giving me the drugs and then see you later.***

Vicky

.....



***Makes it worse. All it will do is keep it down, press it down and then when it does come out again the wave is bigger.** They can't cope with your wave, then they'll give you another drug to put you down again and then the next time the wave will be bigger still and they haven't got a clue.*

Cathy

.....

4.3 Impact of poor services

Analysis of the 2015 survey suggests that poor experience of a service may not necessarily be important just in terms of representing an absence of adequate support. The survivors described how **poor experiences, particularly with statutory organisations** previously, had established a sense of distrust within them which made their engagement with further support services difficult.

There is some evidence to suggest that a poor service experience can represent a barrier to further service use³⁸ and our study overwhelmingly supports this finding. Again, satisfaction is closely linked to whether respondents felt listened to, believed and respected.

Maeve told us that as a **result of her poor experiences with private counselling**, she had not accessed any further support services:



***I didn't want her to make me feel better, but I did want her to make sense of these awful thoughts that were troubling me.** So I just remember thinking I can't do this anymore. I stopped and didn't access another service for about 14 years.*

Maeve

.....

Neil also discussed how the response he had received from a mental health professional had prevented him from accessing further support:



The mental health coordinator told me to man up. He said, everyone gets depressed and down.

I told the mental health team last year, that was how I felt now but, they didn't care, they didn't know what to do. I'm still like it a bit now, I'm really messed up and that. It really bothers me. I just don't want to carry on living, really. I want to end my life. I just don't care anymore. The situation now is terrible.

Neil

.....

These findings suggest that survivors who fail to find a satisfying service go on to access more services over a longer period of time than those who receive a helpful service response at the outset.

In addition to these findings, **the majority of the survivors in our study discussed how a deterioration in their**

³⁸ Smith et al. (2015).

general well-being, and the manifestation of a variety of psychological problems which had arisen as a direct result of their abuse, was further compounded by poor responses to their disclosures of sexual abuse in childhood and ineffective services as detailed in 4.1.

This lack of effective support often left survivors in a vulnerable and isolated position which added to their suffering. This is effectively outlined in the 'Survivors Voices' interviews (2015): 'as a result, most survivors faced years of ineffective therapy which made them feel more vulnerable and damaged, often blaming themselves for the lack of therapeutic success.'³⁹

12 survivors revealed that they had either considered or had attempted to take their own lives, and seven had self-harmed, often prolifically while waiting for or attending ineffective services. Other studies also show a higher incidence of history of CSA among those who have attempted suicide compared to those who have not⁴⁰ as Tom's quote below so poignantly illustrates:



I was just left to deal with what I'd disclosed on my own, which caused the self-harm to get worse, and I also tried to end my own life.

Tom
.....

Therefore, it is clear from the survivors in our study that the labelling and medicalising of their presenting symptoms often made the problems worse. Providing a more effective service much earlier would have saved time, money and, most importantly, mitigated prolonged suffering.



*If [only] someone a few years ago had taken the time to sort me out, **nipped it in the bud instead of prescribing drugs** all the time and letting it snowball.*

Maxine
.....

Self-referral into specialist services

The consequences of delayed or ineffective support and impact of mental health were often the reasons/triggers for seeking help or self-referring to a specialist sexual violence organisation. It became obvious through the narratives that survivors had tried often to get the 'right' support with different types of therapy.

Self-referral into specialist services (those identified as offering specific and specialist support for sexual violence) often followed periods of severe difficulty managing symptoms and effects of abuse, requiring high levels of resilience and determination to access. This step was described by all the survivors we interviewed and was often described as a last resort.



*I was lucky: I had the gumption to go out there and find help. **I know lots of survivors can't do that, get help.***

Beth
.....



*I've lived with anger for such a long time without knowing why. **I was desperate for help.** I was ravaged by PTSD so I referred myself. All the support I've ever had, I've found myself.*

Kirsten
.....



***You can't work out your whole life in six sessions.** Six sessions? You're opening up a can of worms. It's so important to have somewhere to go when you're ready to talk.*

Helen
.....

³⁹ Survivors Voices (2015). 'Breaking the silence on living with the impact of child sexual abuse in the family environment'. One in Four, London

⁴⁰ Fisher et al. (2017: 67).

5. What works

The following quote from an adult survivor from the 2015 survey exemplifies many survivors' life biographies of numerous expensive, ineffective services which failed to help them. This chapter of the report moves away from the survivors' negative experiences of poor/denied disclosure experiences and poor service provision to document what helped them and what they considered to be effective support as adult survivors.



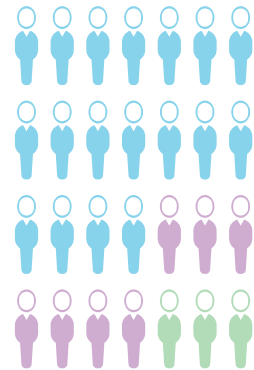
In terms of the sexual abuse, I've had no support, but I have had all sorts of medication, 'therapy', CBT etc. on and off over the last 35 years due to anxiety, depression, suicidality, OCD, living with fear...

The abuse I suffered had never been addressed.

Adult CSA survivor, Focus on Survivors survey respondent, 2015

The analysis of the verbatim data revealed the underpinning principles of successful support provision, the characteristics of that effective support and the positive impact it had on their lives.

18 out of the 28 survivors who took part in our study had eventually found effective support through self-referral; seven via a referral from statutory services (namely GPs and mental health support workers) and three via a referral by other voluntary sector organisations.



When asked what, overall had been the most helpful support they had received, a number of respondents referred not to types of service but to services which had:

Listened to, believed them and respected them



This reflects the findings of the survey in 2015 in that survivors are more likely to find support via their own research rather than from signposting and referral from other services. Other professionals, especially health professionals and police, need to be better informed of specialist help available for survivors so that they can access effective support earlier.

Our study found that effective support can ameliorate much of the damage done by delayed/denied disclosure and that survivors can overcome previous barriers to accessing help if the right help is available to them. It is clear from their life stories that if they had been able to access effective support earlier, years of suffering with the effects of CSA and poor mental health could have been avoided.

5.1 Being listened to, believed and respected - leads to developing trust in services

Morrisson et al's (2018) review suggests, beliefs about others' reactions and the fear of disbelief are major barriers to disclosure in childhood. As per the national survey by Smith et al. (2015), being listened to, believed and respected was of paramount importance to all the survivors in our study. These three principles had provided the foundation for an effective, supportive service for them.



*All the way through nobody ever questions it here. It's not, 'well, could it have happened?' There's never any doubt that you're telling the truth, which is really important, as it's really difficult to disclose without people saying, 'well did it happen?' 'Are you remembering correctly?' – that type of thing, **I'm never put under any pressure to do more than I can manage. I struggle with emotions and so group work isn't good for me. It's person-led which is good.***

Mary

.....

As Allnock and Miller's (2017) study suggests, children who have been sexually abused need to be noticed, asked and heard⁴¹. Similarly, our study found that **adult survivors of CSA need to be listened to, believed and respected.**⁴²

Many of the survivors in our study told us that having their disclosures ignored and denied in childhood had had an impact on their ability to trust professionals in adulthood, as Mark reports:



***I have to try and build a relationship with the person I'm talking to, to feel that I can trust them** because when it was going on I was shouting and screaming from the rooftops all through my childhood and no one was listening and that had a massive impact on my life then.*

My parents didn't even believe me, so I ended up in care. So I don't really trust anyone: authorities, establishment, because they've always wanted to shut me up, push me out the door and not really deal with it.

Now I have to live with the thought that two kids from my school committed suicide and I was shouting about it then. If something had been done at the time those poor kids might still be here, but no-one wanted to know back then.

Mark

.....

The fundamental importance of being listened to, believed and respected underpinned their journey towards recovery, acceptance and developing the skills to manage their feelings and emotions. It also ameliorates feelings of isolation and improved all survivors' mental health and well-being. They all emphasised that these principles should underpin any and all support service that survivors of CSA may access.

⁴¹ Allnock and Miller (2013).

⁴² Smith et al. (2015).



To be heard and to be listened to is absolutely essential because you have spent half your life thinking that one will believe you, so you have to be believed, you know? Not just in words, you've got to feel it.

Sarah

All the survivors described how feeling listened to, believed and respected could begin to negate previous poor experiences with other support services, allowing the development of trust and mediating the innate isolation they had experienced.

Having their experiences validated was facilitated through open, conversational dialogue in which they felt disclosure was possible. As Kate describes below, her initial engagement with her therapist had begun with a simple statement: "Tell me your story." This enabled her to properly disclose for the first time:



*My therapist is a life saver, she's so gentle and kind. **She said to me, 'tell me your story.'** It was such a different approach. She obviously wanted to know my story. It was amazing. I can't think of any better way. A box of tissues later, my therapist explained my tears are my anger; you have such a long story to tell it's been there for so long. I felt like I really wanted her to know what has happened to me [and] I could trust her.*

Kate

Sam described how he felt when he finally disclosed what had happened to him as a child to someone who listened to him and believed him:



*They sat me down and like, asked me a few questions about the abuse and how I felt. **It was like the strangest thing; as I was speaking, they were finishing my sentences, you know? I thought, "Shit, you know, you get where I'm coming from".***

That was the first time since I had come out about it all that someone had been honest about it all; that someone had said to me: "It's okay, we're gonna deal with it. There's no magic wand, it's never gonna go away, you'll always be a survivor but, it's about dealing with it". I could accept that, I didn't want to be fixed, I didn't feel like I needed to be fixed, I just needed to deal with it.

Sam

When the survivors felt that they were genuinely listened to, and that their experiences of child sexual abuse were validated, this had a powerful impact on the guilt and shame that they had been carrying for years, often decades, and the isolation they felt because of it:



My first experience of really, genuinely being listened to was when I attended a group: when I realised myself that I hadn't made this all up, that I wasn't mad for feeling the entrenched loneliness, for being such a fuck up for so long. The therapist read out a long list of validation, stating you have suffered abuse if you have... I reacted as if I had been double barreled by a horse. I could not stop crying.

Kim



*I think I must have sobbed for an hour. **My therapist said, “You’ve never had your abuse validated before have you?”** That was when I knew it wasn’t my shame. For all that time I’d been really stuck with it; it was all my fault, all my fault.*

Kim
.....

Being listened to and believed was the beginning of the journey of acceptance for survivors but also the start of dismantling the silence surrounding CSA, as Dave explained:



To be believed is the important thing and to acknowledge it happened. *It’s very hard to convince yourself sometimes because you’ve always been discouraged to talk about it.*

Dave
.....

Being listened to, believed and respected also enabled the survivors to develop trust in the service and in others, often for the first time:



*Trust is a big, big issue. **Gaining trust to open up when you’re ready is a big issue.** If you haven’t got that in a person you’re not going to open up and so they can’t help you.*

Tom
.....

5.2 Characteristics of effective support - leads to developing trust in others

The survivors all talked about the importance of a safe space and the importance and the meaning of ‘walking in the door’:



*When I first came to [...], the therapist who met me at the door was so friendly. **She had a big smile, which made me feel better because I was so nervous when I first came here.***

Tina
.....

Contacting, phoning or walking through the door of a specialist CSA service is, for survivors, often the first step to disclosure, as Tom’s quote so eloquently illustrates:



Once I came in, it was a different world; to actually walk through that door and feel, you know, I’m not on my own. *I felt at home in minutes. A friendly face means so much: ‘do you want a cup of tea?’ I love tea! I felt safe. They encouraged me to take that wall down and trust them. You need to trust that person to open up. I could do that there [...]. First thing they did was set my mind at rest; ‘you know that you can disclose in your own time, you can do it whenever you’re ready’ – straightaway you’re put at ease. Let’s face it, you came through that door for one reason only and that’s because you’ve been abused. So, by coming through the door you’re saying ‘I need help’.*

Tom
.....

I'll be a **survivor** for the rest of my life.

Once 'through the door', appropriate, specialist support enabled survivors to develop trust and confidence in the service provided in the knowledge that they, like other survivors, could begin their journey to recovery. The participants in our study identified a variety of interventions that had been effective for them, which included, but were not limited to: talking therapies; group therapies; psycho-education; peer support; social engagement groups and opportunities for them to connect with and share their experiences with both professionals and fellow adult survivors. For them, effective support was about making sense of and understanding what had happened to them and the impact this had on their lives and being able to start rebuilding their lives, as Kirsten's quote below illustrates:



*So yeah; a long time of being completely screwed and not knowing why everything was so weird. **It makes sense, now.***

Kirsten

Empathy shown through personal experiences of abuse facilitated real compassion and understanding of the complexities of dealing day to day with the psychological trauma of CSA. The narratives highlight the importance of accessing specialist support services and also being with other people who understood:



*I know some of the counsellors have been abused a long time ago, and it shows you know. **To actually be with someone who's been through it themselves [...] they know what the trauma is like.** They can empathise, talk you through it, give you sympathy when you need it, say well done you managed to come here. They know how hard it is to walk through that door.*

Tom

Having professionals who had had specialist training was also important because of the nature of what they had to say:



*You need a safe place, **with someone who's able to cope with what you have to say.***

Polly

Trust, identified in the previous section as an outcome of being listened to, believed and respected, is a dynamic concept – it does not just happen and can change according to context and other events. The survivors all spoke of the importance of establishing trust and how this is further developed in effective service delivery that is flexible and adaptive to the survivors' own needs:



***Trust is built up over time, but my therapist always adapts the session to the way I'm feeling.** She will never force me to do anything I don't want to do and if I'm not in the right frame of mind she will just listen and just let me go at my own pace, which is really helpful.*

Becky

The survivors spoke of the importance of a flexible, responsive open-door provision which was tailored to their individual needs so that they could take things at their own pace without fixed timeframes. This enabled them to feel more in control of their recovery, something that had been denied them for years, often decades of their lives, and they described how this approach had made them feel empowered in their recovery journey.

Their narratives identified that effective, specialist support services had often been the first opportunity for their CSA experiences to be truthfully validated as real and painful. This was identified by survivors as being the beginning of

their journey of acceptance and understanding of their presenting psychological responses to trauma, which helped them to recognise the indicators of trauma they experienced were normal:



*They've changed my life. I'm forever in their debt. **It's been life changing.** I'm massively open about what happened to me now.*

Mark
.....

The importance of allowing access to support to be guided by the service-user rather than the service provider was identified as highly pertinent to effective engagement. It allowed the development of trust, as identified above, but involved survivors in their own care and support provision. Being flexible to their needs allowed them to feel empowered and more in control of their lives, as Clare's and Alice's accounts illustrate:



*They have been very patient. **They have helped me to disclose at my own pace.** They've helped me to articulate what's going on, instead of it all going on in my head.*

Clare
.....



*It's just taking things slowly, knowing you're not going to be rushed, taking it at your pace. I could be a bitch to my therapist and she would understand how I was feeling. **She was open and honest about things, she just chilled me out.** That's why I did a whole year here. That's the longest place I've been.*

Alice
.....

The importance of shared experience was especially pertinent to male survivors, who identified the benefit of having the opportunity to meet with other male survivors through a group setting:



***I joined a men's group... that was quite empowering in its own right** because I'd spoken to a couple of female survivors but, it was very strange speaking to other men... just weird. I was hoping it would work in the same way AA does and it did, in fact. Someone else started speaking and then it was like, 'you've got [inside] my head haven't you? You're saying how I feel. I don't need to say anything.' I could just look in their eyes and I knew they knew how I felt. You need empathy rather than sympathy.*

Sam
.....

The support provided them with both validation and also an explanation surrounding their sexuality. This further confirmed that their role in their abuse was not their fault, reducing their guilt and shame, leaving having a positive impact on their self-esteem, as Tom explained:



***The group was very helpful.** Not only did it make me feel better about myself but (one of the things that no-one had told me about is) when my therapist explained that when a young man is sexually abused or raped his body reacts in a sexual manner. She explained it was normal, a natural reaction so, I had spent 40 years wondering if I was gay. I'd questioned my sexuality. That one thing alone was an immense thing, you know.*

Tom
.....

I'll be a **survivor** for the rest of my life.

The variety of approaches was also key to effective support. They described the importance of having a variety of avenues and mechanisms to access appropriate support services, which all participants considered vital due to longevity of distrust they had established through recurring stigmatisation, trivialisation and denial throughout their lives.

For many participants, one-to-one counselling had enabled them to understand the psychological and physiological trauma of their abuse and to manage the ongoing effects:



*My therapist taught me a lot about the mind. I like the science of it all. I like to know, **so she taught me a lot about the brain and how things get filed, how your body reacts, which completely makes sense.** [So] rather than get panicked and overwhelmed, I know it's okay. I'm safe.*

Rachel
.....

For Tom, group therapy had enabled him to disclose his abuse to his family for the first time, breaking the wall of silence of 41 years:



*I disclosed to my children roughly 10 months ago, not that long ago. I think it was just after group therapy about a year ago, as a direct result of the group therapy... **I suppose you could say the group therapy gave me the strength to do it.** I don't think I would have done it without the group.*

Tom
.....

All the survivors talked about the importance of listening to and sharing their experiences of CSA with other survivors.

Their narratives suggest this provided both further validation of their CSA but, most importantly, illuminated the fact they were not alone, as illustrated by Polly, Vicky and Kate:



*Group therapy helped me to realise **I wasn't alone.***

Polly
.....



*I started with the walking group. I knew that everyone had been through what I had been through; well, not exactly what I had been through, but they all knew what it was like to be traumatised and then have to live your life with it [...] I really enjoyed it **and I've so many friends through the group.***

Kate
.....



***Talking to other survivors helped so much.** I felt like an alien. I don't know any that it had happened to, you know? I felt it helped when other people had been there and could empathise and understand because they really get it.*

Vicky
.....

Accessing effective help on the phone or on-line, rather than face-to-face support, was also an important aspect of recovery journeys for many survivors, as Tina described:



Being able to phone up and have support, like when I was having a bad day I would ring up and they would stay on the phone with me to make sure I was okay. I think it makes you feel like someone is there for you.

Tina
.....

It is important to remember that 'resilience and recovery are dynamic states; an individual might be resilient at one point in time but not at another.'⁴³



I'd been up all night but I was determined to come. And at the coffee morning last week, I got talking to the therapist and I got the confidence to connect again. As well as [that], I rang up a few times. **If I'm reaching out it means I need help.**

Rick
.....

All participants in our study told us that having a 'safety net' provided ongoing reassurance that help was there if they needed it:



There's no pressure to complete goals by a certain period of time. **They provide a service where you can be supported even when you've left.** It's a thing you can come back to [though] you don't have to. They understand it's a journey and it's not a quick fix.

Wendy
.....

So a key aspect of effective support was that it is not time-limited, and survivors trusted that the support would be there in the future, should they need it, even after a significant period of time:



I've been under this place for three years. I haven't been getting help all through that time, just for a year. But, **I know they are always here, and I can come back anytime.**

Alice
.....

⁴³ Fisher et al. (2017: 45).

I'll be a **survivor** for the rest of my life.

5.3 Outcomes of effective support - developing trust in self

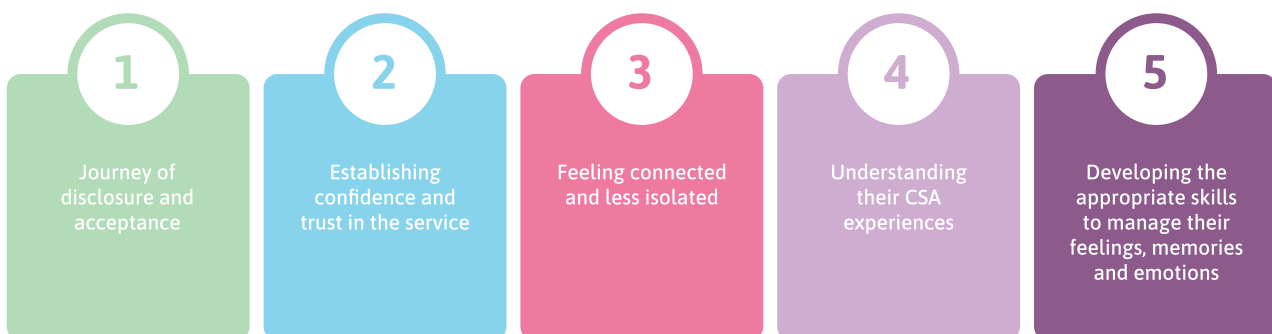


***...Changed my life, and [they] are changing my life.** I'll be forever in debt to everyone there. I did the group programme. You're absolutely terrified, but by the end you're bouncing in. My therapist? There's never any judgement. She resets my mind in lots of ways and the slow realisation it's not you. In a group you look around and think what you just described, that's me. I hadn't vocalised that, that we weren't the cause of it.*

*They're very, very, good at that. **It's not sympathy and a hug, it's life-changing work they do:** 'let's look at who you are, why you are, and let's see how that it's not your fault.'*

Mark
.....

Our 28 survivors shared their experiences of the long and painful journeys to access effective help support. We asked them what, for them, were the key outcomes of an effective support model in which survivors felt respected, believed, and listened to. The analysis of the data from their responses identified five key outcomes:



It is clear from the analysis of the data that effective support does have a very positive impact on adult survivors of child sexual abuse.

Of the survivors in our study, 11 had attempted suicide previously and they said that, had they have had access to supportive services earlier, they would not have done so. Becky had tried to take her own life before accessing an appropriate specialist support service:



If this place had been around years ago, then I probably wouldn't be where I am now.

Becky
.....

The positive impact that effective therapeutic support had on all the survivors' lives was clearly apparent in all their stories. Polly believed that, due to the lack of access to appropriate support services, decades of her life had been lost. But she identified that, with specialist support, her life was moving in the right direction, now saying:



*I guess my 40s had just been written off with all this. I guess it has taken six to seven years to disclose. **But now I have a place that feels safe** [and] homely, to rebuild my life and become a better Mum.*

Polly

.....

Sam, like others, told us how he felt he had been given the tools to manage his flashbacks and reduce the pain of his abuse, while acknowledging the continued journey:



*It's never closed but, **I've been given the tools to deal with it.** I don't think about it much now. Flashbacks don't happen as much. It's easier now it's taken the pain out of it.*

Sam

.....

Many survivors expressed the positive impact their engagement had provided, while simultaneously identifying the isolation they felt outside of the service:



*I'm very much a loner, I think that's very much a survivor's trait, you know. This is my safe house; it's just for me. I felt like this was my last hope. **If it hadn't worked I don't know what I would have done.***

Beth

.....



I feel at home here, I feel safe here. They helped me to accept the abuse, get used to it. But I know I've got to go out in that damn world again. As soon as I leave, I'm lost again. I could walk in front of a bus. It's a different world in here.

Neil

.....

Accessing and engaging effective help and support provided survivors with the necessary skills to regain control of their lives in a variety of ways. Jill, for example, described how through her engagement with one-to-one counselling, she had been able to understand the reasons for the nightmares she had been suffering throughout her life:



*I started to think about it all: I just thought I know I can't change the past, what happened, happened, but I can change the way I deal with it in the future and I needed to change something in my life, change the way I was dealing with it all and change how I felt in the future. **I think for the first time in my life. I don't feel stigmatised or embarrassed...** I still think I could have done more to stop it happening; I think that will stay with me for the rest of my life. But the feelings aren't as negative as they were.*

Jill

....

I'll be a **survivor** for the rest of my life.

Other survivors talked about the positive impact effective support had had on their drug use:



*If you're coming from a background of being abused and things like that, then you're meant to go out into the world thinking you're worth the same as everyone else. That's not gonna happen. The only way I could do that was with a lot of bravado, [and] with a lot of bravado came a lot of cocaine, and with a lot of cocaine came a lot of other problems, do you know what I mean? **For years I thought my problem was drugs but, it's not. I'm not an addict anymore, but I've still got the same problems, do you know what I mean? Being abused, it needs to be clarified right from the off that it's not your fault. But it's too late for that.***

Rick

They all felt that they had been given the opportunity to rebuild their lives and had a variety of new opportunities for the first time. Tina, for example, had been encouraged to embark on a new college course, which she felt had always been a career she had wished to pursue but felt the impact of her abuse had limited that ambition:



***Since coming here, I've been able to apply for a college course.** My therapist encouraged me to go across, so I did. I can't believe I did. When I got home I told my husband where I'd been. He was so pleased and happy.*

Tina

6. Conclusions & recommendations

The 28 survivors we spoke to gave us rich, detailed accounts of their experiences; it was clear from their narratives that their experiences of disclosure and support had been long and, in most cases, extremely challenging. It was clear that they had reflected on their experience and had considered how some of the issues they faced could have been mitigated.

In this report we have focused on disclosure and access to services but through the interviews we discovered and have collated data on many other cross cutting themes which survivors felt were relevant to their journeys, such as parenting, advocacy, family dynamics, revictimisation, impact on personal relationships and inter-generational sexual abuse – in order to give these important issues, the focus they deserve we will be dealing with them in separate papers to be published over the coming year.

The survivors' narratives demonstrate the importance of being listened to, believed and respected in order to develop trust and be able to make a safe, supported disclosure. For many survivors it was the first time they had been able to tell someone their full story. To be listened to, believed and respected by service providers and also by other survivors reduced the stigma and isolation they felt and they were able to begin to understand what had happened to them and the impact it had had on their lives.

From these accounts, it can be seen that the existing effects of sexual abuse were exacerbated at critical trigger points or during key life events. In the disclosure/service access trajectory, there were two further distinct points of decline in survivors' journeys: during the long time-lapse of denied, disbelieved disclosures in childhood and, after seeking assistance from GPs and typically being referred into statutory mental health services. We established a pattern that survivors had generally followed:

1

Denied, disbelieved or did not disclose in childhood

2

Long time lapse

3

Attempted disclose in adulthood

4

Sought assistance from GP

5

Referred into statutory mental health services

6

Symptoms / effects exacerbated / worsen

7

Self referral into specialist service

'Disclosure is now generally accepted as a complex and lifelong process'⁴⁴. Research to date suggests that 'findings from large-scale national probability studies highlight the prevalence of both non-disclosure and delays in disclosure, while findings from small-scale qualitative studies portray the complexity, diversity and individuality of experiences'⁴⁵. There is now a growing body of research with focuses on CSA, but less attention is focused on adult survivors and disclosure⁴⁶. This report is based on the experiences of 28 adult survivors of childhood sexual abuse. It is clear from the narratives that their disclosure journeys were long and difficult and opportunities for disclosure were often denied to them.

The need for rigorous empirical research on child and adolescent disclosures is well documented⁴⁷ but we would argue that this vital research need also extends to adult disclosures. What is abundantly clear is that if survivors had been asked the question, this would have facilitated a less problematic and timelier route into specialist services.

'Identifying and understanding factors that promote or inhibit child sexual abuse disclosures has the potential to facilitate earlier disclosures, assist survivors to receive services without delay, and prevent further sexual victimisation'⁴⁸ **The narratives highlight that when attempted disclosures were met with poor responses (more likely in childhood) from family or professionals (more likely in adulthood) this has detrimental consequences.** Subsequently, further disclosures or attempts to access support were delayed, often for decades.

If survivors had been directed to specialist support services at the point of disclosure they could have avoided years, even decades, of deteriorating mental health and revolving repeatedly through the system.

It was clear from the narratives that GPs were viewed as (and were) a critical catalyst point in the help-seeking process.

Services that were viewed as unhelpful tended to be time-limited, lacked empathy and were too focused on diagnosis and medicating.

When survivors did access specialist support services, this tended to be through self-referral, and viewed as a last resort.

For the survivors, effective support was underpinned by the three basic principles of being listened to, believed and respected; this enabled them to begin to trust and engage effectively with support services.

Successful engagement with a support service was determined by the initial contact experience, being offered safe space and time for trust to grow, which enabled them to begin a journey of acceptance and understanding of their abuse. Successful services enabled survivors to establish confidence and trust in the service and in others, including other survivors (in some cases), which led them to feel better connected and less isolated

The outcomes of effective support are clear. Stigma, shame, isolation and fear are reduced and trust, self-esteem, confidence, mental health and well-being increase and improve. Once survivors have access to effective support, their need for other more generalised services, especially mental health services, is reduced, as the negative impact of delayed disclosure is ameliorated.

For survivors, effective support needs to be flexible rather than a rigid model or programme of delivery. For some survivors, one-to-one support was what they needed initially; others wanted a less formal approach, such as a peer support or group drop ins. And, for other survivors, telephone help and support was most appropriate. **It was clear that their support needs were dynamic and changed over time and with their own developing trust and confidence.** Survivors need to access a range of support services and to be able to access them at their own pace.

⁴⁴ Alaggia et al. (2017).

⁴⁵ McElvaney, R. (2015, p. 159).

⁴⁶ Tener and Murph (2015).

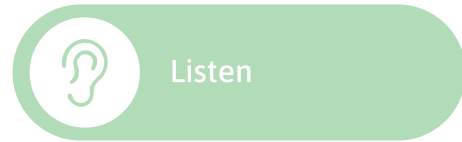
⁴⁷ Lemaigre et al. (2017).

⁴⁸ Alaggia et al. (2017).

This enabled them to further develop trust, while also feeling more in control of their recovery pathway. Having a menu of interventions and support activities which survivors can access and which are not time-limited are essential to effective support.

Effective support can both change and save lives; this is clear from the accounts of the 28 survivors, and this also includes the lives of their families too.

The following **3 key concepts** should be seen as a minimum requirement:



Recommendations

All professionals who are likely to come into contact with adult survivors of sexual abuse should be identified, and need to understand the importance of the 3 key concepts of listen, believe and respect, as a minimum requirement

Further research and understanding is required into disclosures of childhood sexual abuse made by adults, to better understand and respond to these

The vast time lapse between disclosure and effective support needs to be better understood, costed and mitigated by swifter referral into specialist services

Survivors own views are critical in understanding how they are referred, move between and access service provision, and should be included as standard practice in any future research

GPs should be encouraged to refer survivors into specialist services, rather than mental health services at the point of disclosure

More effective cross sector working is essential to providing the right support for survivors, at the right time and therefore improved communication and clear referral pathways between sectors must be prioritised

The burden of disclosure needs to be alleviated through professionals identified as 'trigger points' in survivors' journeys (GP's, Mental Health, Emergency and Hospital Staff need to be trained and working in a 'trauma informed' environment, where 'asking the question' is routine, disclosure is made easier and the response consistent and timely

Local specialist services need to be more 'visible', both to relevant, referring professionals but also to survivors to ensure that vital self-referrals can be made

A gap analysis of service provision is required across the UK, with a clear understanding of local and national commissioning responsibilities

Effective, specialist service provision which provides individualised and flexible responses to survivors' needs must be better, more sustainably funded and recognised as a cost and time, if not lifesaving part of the overall system

Private therapists need to clearly state their ability to work with trauma and sexual abuse, and those who are not competent or qualified in these areas should signpost clients on as appropriate

It is clear that when the right support is offered at the right time survivors feel
'I'll be a survivor for the rest of my life'

Thank you to the following organisations
who assisted with the report:

Report copy, proof and structure:

copywriting
& creative communications

The Manor House

St Margaret's Green, Ipswich IP4 2BS

Tel: 01473 212112

Fax: 01473 211508

Mobile: 07751 430363

Skype: copywriting_and_cc

Report design and infographics:

Rubious
web · graphics · marketing

Rubious

Unit 2 Brightwell Barns

Waldringfield Road, Ipswich IP10 0BJ

Tel: 01473 356403

Email: info@rubious.co.uk

www.rubious.co.uk

Report Printing:

HEALEYS

Healeys

Unit 10-11, The Sterling Complex, Farthing
Road, Ipswich, Suffolk IP1 5AP

Tel: 01473 461122

Email: info@healeys-printers.co.uk

www.healeys-printers.co.uk