



Yes You Can!

Working with Survivors of Childhood Sexual Abuse
Second Edition

by Sarah Nelson and Sue Hampson

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Yes You Can!

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Second Edition

by Sarah Nelson and Sue Hampson

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FOREWORD by Shona Robison,
Minister for Public Health, on behalf of Scottish Ministers



Yes You Can! has been developed for people working with, or likely to be working with, survivors of childhood sexual abuse. People present to frontline services with a range of issues which may relate to childhood sexual abuse and this booklet has a particular focus on the impact that childhood sexual abuse can have on mental health and wellbeing. Not all survivors need, or wish, medical intervention, and many seek counselling and support services. This booklet aims to support people working in a wide range of services to gain a better understanding of the needs of people who have experienced childhood sexual abuse, how best to raise this sensitive issue, and how to respond in an appropriate and supportive way.

There has for many years been a widespread misunderstanding of the needs of survivors of childhood sexual abuse and sometimes a reluctance to raise the issue because of societal fears and because of the stigma which can be associated with this sensitive subject. It is essential, though, that service providers, practitioners and professionals feel confident, informed and able to support people. This resource aims to make a significant contribution to that.

We would all like to think that childhood sexual abuse doesn't happen but if people across Scotland are aware of the reality then it is more likely that good support and understanding will be available to survivors. Childhood sexual abuse has a significant impact on individuals, families and communities. Evidence indicates that people who have experienced childhood sexual abuse are at greater risk of social, physical, emotional and mental health problems in adult life; for example, such individuals are more at risk of self-harm and suicide than the general population. This makes it all the more important that, when they need to access social, healthcare and other services, they can do so without fear or trepidation and in the knowledge that they will be given strong and appropriate support.

This booklet has been strengthened and endorsed in a review carried out by the Scottish Government with advice and input from a stakeholder review group that included the voluntary sector, social work services, survivors' representatives, psychiatrists and psychologists. It reflects the Scottish Government's policies on improving mental health and wellbeing, improving services, improving the quality of life for people who experience mental illness, supporting and promoting recovery, eliminating stigma, promoting social inclusion, and saving lives by helping to prevent suicide. Its cross-cutting nature makes it relevant to health, education, criminal justice and communities, and to the voluntary, statutory and private sectors.

In 2005, the then Scottish Executive launched the National Strategy for Adult Survivors of Childhood Sexual Abuse to help improve services for survivors, to ensure greater priority and joined-up working in national and local mainstream services and to improve the lives of all who have suffered childhood trauma. Following this, a National Reference Group, which includes survivors and representatives of a wide range of voluntary and statutory services, was set up to take the strategy forward, a major conference was held in 2007 and the Survivor Scotland website has been launched. Part of the strategy is about addressing the need for better training and good practice guidelines. This booklet is an important part of the process.

I hope you will find *Yes You Can!* useful.

SHONA ROBISON

Minister for Public Health

2008

INTRODUCTION

This booklet has been written for people who often find themselves at the frontline working with, or likely to be working with, survivors of childhood sexual abuse. It aims to help staff to become better listeners but it is not asking frontline staff to become therapists. Survivors need their stories to be validated and heard and staff need to know how to respond to initial disclosures in a safe way but they also need to know how and when to refer on.

It offers important basic information, advice and good practice guidelines for working with male and female survivors. We hope it will help you feel more confident to raise the issue of sexual abuse with service users, where appropriate, and to support people who disclose. This booklet is not a stand-alone resource, but part of a programme of activities around child sexual abuse by *health in mind* and its partner organisations, including training for frontline workers, information, and research with sexual abuse survivors.

The information in this booklet will prove helpful to a wide range of people in the statutory and voluntary sectors, including staff and volunteers working in mental health, community projects, counselling and support services, health and social work services, homeless projects, addiction services, and older people's projects. It will also be useful to those working in criminal justice and children, young people's and families services, even where the impacts on others are paramount; see Appendix Three: Concerns about the safety of children and ongoing concerns about adults.

The booklet outlines what sexual abuse is and what its effects can be. It looks at barriers to survivors speaking out, and at common fears among staff and volunteers about raising the issue with users or responding to a disclosure. It says a bit about the attitudes and approaches which survivors value as helpful, and those they find unhelpful. It sets out some good practice points for broaching the topic, responding to disclosures and 'being with' survivors in a one-to-one setting. It also makes some points about wider issues of support planning. Finally, it gives contact details for some useful organisations, notes issues around limits of confidentiality and has a list of resources.

The booklet has been written primarily for people who are working with adult survivors. We believe that the general principles outlined here are also relevant for those working with children and young people. However, there are additional considerations for these workers, most notably child protection guidelines.

As the authors, we would very much welcome the development of materials for work with young people which integrates these principles with any constraints which are genuinely necessary in the interests of young people themselves.

Direct quotations from survivors in this booklet are taken from:

- › Nelson, S. 2001. *Beyond Trauma: Mental Health Care Needs of Women who Survived Childhood Sexual Abuse*. Edinburgh: *health in mind*
- › Nelson, S. 2004. *Adult Male Survivors of Childhood Sexual Abuse, Needs Assessment: Lothian*. Edinburgh, *health in mind* (obtainable directly from *health in mind*)
- › Malone C. Farthing L. Marce L. (eds) 1996. *The Memory Bird: Survivors of Sexual Abuse*. London, Virago
- › Dale, P. 1999. *Adults Abused as Children*. London, Sage

This booklet has been reviewed and amended by a panel of mental health professionals, including psychiatrists, psychologists and representatives from adult survivors' groups, who are content with it.

We would like to thank Dr Margaret Hannah, Consultant in Public Health, for chairing the Review Group, Gregor Henderson, Director of the Scottish Government's National Programme for Improving Mental Health and Wellbeing, and Lauren Murdoch, also of the Scottish Government, for their assistance in producing this booklet, Julie Dick of *health in mind* for her help compiling this resource, other staff of *health in mind* and the members of the Review Group, who have contributed much time and effort to reviewing the booklet, and the many people within the Scottish Government, who assisted in the development and production of this booklet. We would also like to acknowledge the late Bill Bennett's work, former Chief Executive of *health in mind*, including his helpful comments on early drafts of this booklet.

Sarah Nelson
Sue Hampson

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Definition of Child Sexual Abuse

A formal definition, from Scottish child protection guidelines, says child sexual abuse happens “*When any person, by design or neglect, exploits the child ... in any activity intended to lead to the sexual arousal or other forms of gratification of that person or any other person(s), including organised networks. This definition holds whether or not there has been genital contact and whether or not the child is said to have initiated, or consented to, the behaviour.*”¹

Sexual abuse is also physically and emotionally abusive. It breaches the personal boundaries to which all human beings are entitled. Child sexual abuse is always wrong and involves the misuse of power and control.

What Does Child Sexual Abuse Involve?

“Today I live with a rage and sadness that rules my life. I feel I shall never be a whole human being. My mum used to say you shouldn’t live in the past. I don’t. The past lives in me.”

Many people imagine child sexual abuse is ‘a bit of fondling that shouldn’t happen’ or ‘inappropriate touching’. In considering the effects which people may be left with for the rest of their lives, it’s important to realise that CSA often involves serious and very degrading assault. It may include:

- ▶ **‘Non-contact abuse’** Although sometimes regarded as insignificant, this can include: being watched (often daily) in private situations, like going to the toilet or having a bath; being forced to watch the abuser masturbating; being made to watch group sex or pornography, and a range of other perverse acts, including sex with animals, young children or even babies.

¹ Edinburgh and the Lothians Child Protection Committee (2003) *Child Protection Guidelines*, Edinburgh

- › **‘Contact abuse’** can include vaginal, oral and anal assault by one abuser or a group; penetration with objects or weapons; forced participation in group sexual activities; forced acts with animals; involvement in child prostitution and pornography; forced abuse of other children; being urinated on, and other forms of ritual humiliation.
- › **Additional physical violence** during abuse which survivors have reported includes burning, scalding, electrocution, pulling of hair, use of weapons, beatings, having their wrists and ankles tied, being isolated, drugged, or deprived of sleep, food or drink.

The abusive acts and additional physical violence, or perverse scenarios, might be filmed for the purpose of making and selling pornography. Captured internet child pornography reveals that these acts may be inflicted on very young children and babies, as well as on older victims.

The Impact of Child Sexual Abuse

Many people who experienced sexual abuse as children live successful lives, despite their adverse experiences. Being sexually abused does NOT mean people will necessarily suffer the problems referred to below. Survivors of child sexual abuse can be affected to very different degrees, and some might only have difficulties in one particular area. However, child sexual abuse can have lasting, serious and wide-ranging effects, such as those discussed below. It is important to remember that not all people who manifest these symptoms will be survivors of childhood sexual abuse. The list provides a guide but staff are reminded that they are listeners, not therapists, and your role therefore is not to diagnose but to listen and validate what the person is saying.

In general, the most pervasive effect of childhood sexual abuse is the destruction of self-esteem and the generation of a sense of worthlessness. It is not hard to understand why people who have been sexually abused might feel worthless: they have been used as objects, purely for the gratification of others. Their own feelings counted for nothing. They have often been ritually humiliated and repeatedly degraded because others find this exciting. Their personal privacy has been profoundly invaded. Their abuse has often been as a result of betrayal by those they trust, love and depend upon, which may include one or both of their parents.

“I used drugs to get away in my head. I didn’t care at all about myself. I thought nothing of myself ... you reach so much desperation.”

Some Major Effects

The major effects of CSA have been widely researched and documented. We can only summarise here some key issues which you may want to read about in more depth. The impact of sexual abuse does not make a person abnormal – the effects listed below can be common and normal responses to trauma. It is when they persist and cause problems in survivors’ lives that treatment and support are valuable. The voices of survivors quoted below give a better appreciation and understanding of the physical and emotional costs of abuse, and an insight into the behaviour of some survivors.

There is good research evidence that people experiencing particular mental health problems, including post traumatic stress symptoms (PTSD), borderline personality disorder, depression, problems with food, suicide/attempted suicide and self harm, severe substance misuse, anxiety disorders and loss of self esteem, are more likely than others to report a history of childhood sexual abuse. Sometimes the associations are very strong. For instance, many people with histories of CSA trauma have consistently been found in those diagnosed with borderline personality disorder.

› **Depression:**

Depression is a widespread problem in society, and there are many contributory causes. It is very common for survivors of sexual abuse to suffer debilitating bouts of depression during their lives, especially at times of particular stress, or when experiences trigger memories of abuse. For women, one of these trigger points can be pregnancy (which often involves intimate examinations) and the birth of a child. An unrecognised history of sexual abuse can make response to treatment more difficult, and hinder recovery; focusing on the trauma can aid recovery.

“I thought this is terrible, I have a lovely baby, what’s the matter with me? Feeling terrified for what would happen to my children, that someone else might abuse them...I felt suicidal the whole time. Childbirth brought up floods of memories.”

› **Post traumatic stress (PTS) symptoms, such as flashbacks, night terrors, phobias, anxiety states or panic attacks**

Post-traumatic stress symptoms are familiar not just to sexual abuse survivors, but to people who have experienced many forms of trauma. These symptoms can include flashbacks to the traumatic incident, and avoidance of situations associated with the trauma. These are normal responses to abnormal events, not signs of weakness or irrationality. What is perhaps more difficult to appreciate is just how disruptive, distracting and disturbing PTS symptoms can be to survivors’ everyday lives, to the performance of everyday tasks, and to their physical health. Survivors may live continually on edge, what therapists call ‘hypervigilance’. The symptoms are exhausting! They can also lead people into sometimes desperate attempts at self-medication.

In addition to avoidance of feared situations or objects, some survivors experience phobias related to their abuse, such as agoraphobia or claustrophobia. While their phobia may initially sound irrational, sensitive enquiry can sometimes reveal that the

person has good reason to be scared: they may, for instance, have developed a fear of the dark after being locked alone in a cupboard for days. They may have a generalised anxiety that leaves them with no self confidence. They may have bouts of being unable to work, with panic attacks, a sense of not wanting to be seen, and sometimes even agoraphobia. Survivors may have difficulty sleeping, need to sleep with the light on, and may wake up panicky or depressed.

› **Self-harm and self-mutilation:**

Self-mutilation (cutting, burning or otherwise physically injuring yourself) is strongly linked to childhood trauma, including sexual, physical and/or emotional abuse. Self-harm and self-mutilation are particularly hard for other people to understand and often make them feel upset or disgusted. This revulsion can sometimes result in great unkindness to distressed survivors. What may be a coping mechanism for the survivor is sometimes wrongly seen as attention-seeking (although most of it actually takes place unseen and in private). It is helpful for workers to read as much as possible about the causes of self-mutilation, in order to develop more understanding and to work with survivors on constructive ways to reduce their self-mutilation. NHS Health Scotland has a booklet about this.

Self-mutilation can be quite distinct from attempted suicide. Indeed the person may see it as one means of survival. The causes are complex and can be about several things, including: attempts to regulate overwhelming feelings; self-hatred and self-punishment; a sense that abusers are ordering them to do it; or compulsive re-enactment of an abusive experience. For instance, one survivor in *Beyond Trauma* kept inflicting very severe burns on her arm before recalling that, as a child, her abuser had repeatedly burned her arm on the cooker. Self-mutilation can bring temporary relief from distressing thoughts or feelings, or a feeling of euphoria.

“It’s a desperation, an absolute desperation, where you’re feeling so much pain within you, and there’s other times when I felt so dulled I couldn’t feel anything at all, and wanted to feel something. There was so much pain within me that I almost needed to do something really extreme to relieve it.”

Self-harm in a wider sense can take many forms. For males especially, it can involve compulsive risk-taking, heavy drink and drug misuse, and/or extreme lack of self-care.

› **Suicidal behaviour and thoughts:**

We will never know the exact relationship between child sexual abuse and suicide because so many people’s histories remain secret. However, those who work with people who have experienced CSA cannot fail to be struck by how often suicide or attempted suicide is a feature. For instance, 50% of the interviewees in the *Beyond Trauma*² study revealed that they had tried to kill themselves – sometimes repeatedly. Some survivors may experience such serious and persistent distress that they feel like they want to go to sleep and never wake up, and may take overdoses of drugs in order to dull or deaden the pain they experience.

Suicidal behaviour among male CSA survivors is also common, and life-threatening forms of risk-taking behaviour are often more extreme for men than for women. Most male survivors interviewed for the Lothian needs assessment³ had attempted suicide, sometimes several times: “Actually I tried at the ages of 6, 16 and 17, and it wasn’t picked up...”

² Nelson, S. (2001) *Beyond Trauma: Mental Health Care Needs of Women who Survived Childhood Sexual Abuse*. *health in mind*, Edinburgh

³ Nelson, S. (2004) *Adult Male Survivors of Childhood Sexual Abuse, Needs Assessment: Lothian*. *health in mind* and NHS Lothian, Edinburgh

Indirect Murder

When all is said and done,
As if it ever could be,
The issue of suicide is not one
That rates much sympathy.

Murder, for some reason, is more
Written about and understood.
To the box office, glorified gore
Is artistically valued and good.

Murders and murdered are news. Fame
Or even notoriety is their lot.
Suicide is looked upon with shame
As something it's better we all forgot.

Yet suicide is murder in disguise,
Caused by some unremembered crime,
Not understood by our present eyes,
For it has its roots in an earlier time.

Because we don't know the beginning
Of such long-term murder, we see
Suicides as people who are sinning
And reject them accordingly.

Those untouched by such murder, in resentment
Or fear, not knowing enough about
It, come up with some facile comment
Such as 'suicide is the coward's way out'.

Like primitive man, who saw
No relation between sex and birth,
And later man, whose immature and raw
Greed fatally threatens the earth,

We seem totally unable to relate
Effect to a cause that isn't obvious to see
Or to realise that a suicide's state
Is murder rooted in personal history.

Not by something as obvious as a knife
Or a gun, but by acts that the perpetrator
Cannot recognise as threatening to life
Because the dying happens years later.

Brenda Nicklinson

With grateful thanks to Malone C. Farthing L. Marce L. (eds) 1996.
The Memory Bird: Survivors of Sexual Abuse. London, Virago

› **Alcohol and drug misuse:**

Many people in our culture, especially young adults, misuse drink or drugs. But prolonged, repeated and intractable misuse, repeated failures to detox, and misuse at an early age should alert workers to the possibility that this person is self-medicating in an attempt to deal with effects of a trauma, such as sexual abuse. (It is also important to remember that the misuse can be of prescription drugs.) In particular, it may be an attempt to get rid of flashbacks, nightmares, frightening memories, intrusive thoughts or the hearing of voices. Alcohol and drug misuse is also connected with self-harm and lack of self-care. Additional services may be required to enable adult survivors to give up alcohol and drugs when they are being used to manage difficulties relating to the early trauma.

“I think I just felt desperately unhappy ... you would drink and drink and drink, just to blot everything out. I started having – like blackouts – things were happening, like (my) shop got smashed up and I thought someone had broken in, and it was probably me ... there was glass everywhere. I started drinking a couple of bottles a day ... neat gin ... I was getting into more and more debt, and I started going downhill rapidly.”

› **Anger and aggression:**

Anger and aggression are particular problems for survivors and can be internally or externally expressed. As a male survivor recalls:

“I felt I was taking 20 years of aggression out on somebody in the pub. Men can be torn up with anger. If they are forced to suppress it all, they are likely to explode. They could find themselves doing a long (prison) sentence for attacking someone ... you have this aggressive body language, swearing, and the physical pain too, which can make people very angry and frustrated, very uncomfortable.”

Another remembers:

“It took over my life. I was so determined that it wouldn’t happen to me again, so afraid, I beat other people up. I was violent, I ended up in prison many times. Other people remember the records they played at that time – I remember the fights.”

When faced with institutions (hospitals, prisons and other places with formal procedures), a survivor can feel a loss of control and power: there is little or no personal space, no privacy, and no escape. This is like a replay of the abuse situation, and can result in a great deal of fear, anger and hostility. This can be misjudged as the person being a ‘difficult customer’, but it makes a lot of sense when traced to the underlying cause.

› Eating problems

A significant number of survivors have problems with food and with eating for a variety of reasons. Causes can include a determination to exercise some control over one’s powerless life; self-hatred; reactions to oral assault or to the forced ingestion of noxious substances; self-comfort in compulsive eating; attempts to be unattractive to abusers, or to avoid sexual relationships generally; the wish (with anorexia) to prevent pregnancy, or sometimes a wish to die.

“It’s wanting to reclaim some sort of power over my body, because my body hasn’t been mine for so long, but also because there was a lot of self-hatred.”

“Food issues were always around the abuse. They were kind of inseparable. For instance, the dish of sweets as a reward ... the link has persisted with me.”

› **Physical ill-health**

Physical effects of CSA can include genital and anal damage, sexually transmitted diseases (some of which can also reduce fertility), pelvic inflammatory disease, and gynaecological problems. Some of the psychological effects of sexual abuse, such as eating problems, suicide attempts, substance misuse, and depression, can also seriously affect physical health and self-care. Chronic pain is common, and can come from the effects of injury, or from the physical expression of emotional pain. Survivors may present often at their GPs over long periods, with no apparent reason found for troublesome, disabling physical symptoms (e.g. recurrent chest pains, breathing problems).

Symptoms of PTS, such as continually disrupted sleep, can be exhausting. Survivors who run away from abusive homes can have their physical health jeopardised by the unhealthy and dangerous environments they encounter while living on the streets. Many survivors also suffer medically-unexplained conditions, such as irritable bowel syndrome.

Physical ill-health also results from declining or avoiding preventative checks. This frequently includes the reproductive areas for both sexes, ante and post natal checks, smears and dental checks.

“Self-hatred has made it impossible at times to listen to myself or believe I am important enough to have health needs. Denial has made me simply cut off physical sensation, dismiss pain as being silly. Social isolation has ... cut me off from care, support and feedback about my health ... illnesses have dogged my life.”

› **Relationship problems and dysfunctional sexual relationships:**

Many men and women who have been sexually abused may need to re-learn appropriate boundaries which keep them safe in their relationships. They may acquiesce to things they are unhappy about and may be unclear about what is or is not acceptable behaviour. As a result they are vulnerable to being 'walked over', exploited, disrespected or transgressed physically or emotionally. In extreme situations this difficulty in creating and maintaining appropriate boundaries can lead to re-victimisation or to survivors ending up with abusive or bullying partners. Expecting no better for themselves, they put up with aggressive or controlling behaviour, believing that this is the norm or that they deserve to be treated badly. Some survivors have not had good role models for relationships, and consequently accept unreasonable or inappropriate behaviour from those around them, while others may act inappropriately themselves, perhaps continuing the patterns of violence they experienced in their own childhood.

It also is not uncommon for survivors to have some confusion about, or difficulty with, sexual feelings or behaviour. Most of us can understand how experiencing sexual abuse might turn some people off sex altogether or cause various other problems such as unpleasant intrusive flashbacks during sex or avoidance of physical intimacy, even with trusted partners. It can be more difficult to understand survivors turning to apparent 'promiscuity' or sexual risk-taking. Teenagers, in particular, are often stigmatised for this, instead of their behaviour indicating possible abuse and a need for protection. Such behaviour can result from feelings of worthlessness and self-hatred, from experience of only being valued for sex, or from a lack of appropriate physical contact and care in childhood:

“I used to go to Calton Hill and go with any man, and do disgusting things, the lowest things I could, because I felt so totally bad about myself. But it didn’t actually help, in fact it made me feel even worse afterwards. But it was like a compulsion.”

Many survivors also experience some confusion about their sexual orientation. Those who are as adults attracted to people of the same sex may worry that the abuse ‘made them’ gay, lesbian or bisexual, and consequently can feel bad about their sexual feelings, while heterosexual male survivors abused by men may worry that their abuser thought they were gay and chose to abuse them as a result. Linked to this, they may develop homophobic feelings or present as very macho. Survivors can also feel enormous guilt and confusion about sexuality if they had a sexual response to the abuse, perhaps assuming that this must mean they enjoyed the abuse or wanted it to happen. In fact, a sexual response to being abused can be a result of the high adrenaline caused by fear and anxiety or a normal physiological response of the body unrelated to sexual enjoyment.

In wider relationships, it is also very common for adult survivors to have disrupted relationships with non-abusive members of their families. This can be a cause of continuing sadness and loss for all concerned. Many feel bitter and perplexed that their mothers, or other adults, did not intervene to stop the abuse. Survivors who ‘blow the whistle’ on abusing relatives can sometimes find themselves isolated in the family – other abused members of the family may feel unable to speak out and support them. On the other hand, many survivors have also had very rewarding experiences of repairing family relationships after the abuse has been brought into the open.

Abused people who themselves become parents can be overprotective of their children, unable to leave them with babysitters or with non-abusing family members. They may be

particularly anxious when their child reaches the age they themselves were first abused, as this can bring up many unpleasant memories or flashbacks. Parents may also worry about their own parenting and can be very concerned about abusing or neglecting their children. Sometimes they might avoid appropriate physical contact or routine care out of this concern. They may find it very hard to display affection to their children, although this doesn't mean that they don't care.

› Dissociation

Reactions to overwhelming, traumatic situations are often described as fight, flight or freeze responses. Where children can't escape their situation or fight back they may freeze, with their bodies and minds 'switching off' or 'going elsewhere' for the duration of the trauma. This is a form of dissociation. For example, some survivors recollect feeling distant from their bodies while the abuse was happening, viewing it as if it was happening to someone else.

Dissociation happens when some thoughts, emotions, sensations or memories are separated from the rest of our conscious awareness. It exists along a continuum from feeling slightly disconnected and distant through to memory blackouts and an inability to recall significant periods of time. Some degree of dissociation is normal. For example, most of us can't recall what we've been thinking about during a long train journey: our minds are simply 'elsewhere'. Some memory gaps about parts of our childhood are also common. However, severe and problematic dissociation in adults is more frequently found amongst people who have experienced different kinds of abuse and trauma in childhood.

The most common forms of dissociation are depersonalisation and derealization. This is where things seem unreal – the survivor might feel detached from their body or from their surroundings, experiencing things in a slightly vague, distant and dreamlike way. Sometimes survivors have described this as feeling as if their life

was a film they were watching rather than something really happening to them. Dissociative Identity Disorder, formerly called Multiple Personality Disorder, is where the mind is thought to split into several personalities, who may or may not have awareness of one another. This is the most controversial form of dissociative disorder. While some mental health professionals doubt its authenticity as a disorder others believe it is a response to overwhelming trauma, with the mind splitting off parts it is otherwise unable to cope with.

In adult life dissociation can sometimes be behind apparent mood swings or personality shifts, forgetfulness, dreamlike states, inattention or memory loss for periods of time. It can be frightening and distressing for survivors if they can't remember where they were or what they were doing for some hours.

It is helpful for survivors who experience dissociation to work with a trained professional to find ways of 'grounding' themselves in order to improve their psychological contact with themselves and the world.

▶ **Personality disorders**

There are a range of recognised personality disorders, including Borderline Personality Disorder and Antisocial Personality Disorder. Research suggests there is a relatively high prevalence of diagnosed personality disorders among people who experienced traumatic neglect and abuse in childhood. As infants and young children we are totally dependent on our care-givers to meet our needs for survival and for comfort. We also begin to develop a sense of who we are in the world through these early relationships. Unfortunately some care-givers behave in a neglectful, inconsistent, inappropriate or abusive way, which can affect our sense of identity as well as the way we relate to others in adult life. Personality disorders are characterised by long-lasting inflexible patterns of thought and behaviour which cause significant difficulty in adult life and relationships.

For survivors, these diagnoses raise problems as the label of personality disorder is experienced as stigmatising. For many, the diagnosis of personality disorder has become a 'dustbin diagnosis' for people who behave 'badly', abuse substances, self-harm frequently, or are considered 'hard to treat'. This can result in services, or hospital admission, being denied because of a belief that there are no effective treatments for personality disorders, or that the person is simply attention-seeking. It is hard for staff and volunteers to perceive the extent of post-traumatic distress and suffering beneath the apparently exasperating behaviour. This can lead to survivors spinning through the 'revolving doors' of prison, psychiatric hospital, streets and A&E.

In recent years, with increasing dialogue between scientists and clinicians, there is a greater understanding of the development of personality difficulties, the neuropsychological implications of the problems and the existence of successful psychological and pharmacological treatment interventions. See page 50 for some information on the Scottish Personality Disorder Network.

Survivors with personality disorders can be challenging to work with: because of their difficult childhood experiences they may relate to others in ways which are very difficult to cope with. They may be mistrustful and suspicious, apparently uninterested in relationships, or may swing between being very needy or dependent at one time and hating us at another. Self harm is common, as is dissociation (see previous section).

It is vital that you provide safe, appropriate and consistent relationships in these situations. You need to respond to the distress rather than to behaviour which may appear provocative. This requires compassionate but firm professional boundaries around time, contact and our role. You are not there to be a substitute for friendship or for other relationships, but this does

not mean you act coldly. Survivors may never have experienced a caring person who acts appropriately, does what they say they will do and doesn't go beyond what is appropriate to their role and competence.

Providing this kind of relationship can create an opportunity for survivors to experience people differently – not as abusive and rejecting, or collusive and cloying, but as responsible adults. This means you need to be able to tolerate being loved and/or being hated, without taking it too much to heart or changing our own behaviour and response to the survivor as a result. Over time this can help survivors change their sense of self and their behaviour.

One female survivor diagnosed with Borderline Personality Disorder recalls a nurse whose skilled therapeutic help enabled her to change her life:

“I was totally outrageous. Throwing myself on her, pleading and begging with her, lying on the floor: I don't know how she survived. Yet she never overstepped the boundaries, but not once was she ever cold, she always behaved in a warm kind way ... I think when things got intolerable, I must have been hell to work with.”

› **Psychotic episodes**

Some survivors experience what may appear to be psychotic episodes at stressful points in their lives, or during flashbacks of abuse. Some hear the voice of their abuser(s) or experience intrusive thoughts about their abuser's derogatory comments. There can be confusion between post traumatic stress and psychotic episodes, although the two can also occur together. It can require a skilled and trained person to make these distinctions accurately, and frontline staff should seek advice when they are concerned about the significance of psychotic episodes.

Reflection

The list of effects discussed above reveals the pain and distress which many survivors of CSA have had to live with since childhood, whether or not their silence has been broken.

Looking at the effects of abuse, it is difficult to understand why so many people appear sincerely to believe survivors are somehow all right, and stable, left as they are, and that trying to help them by addressing the issues would make them “worse”. It is very important to be honest with ourselves and ask whom this notion protects. There is an anxiety that trying to help survivors explore issues can worsen things and in some situations they may indeed feel worse before they feel better. However, people who try to kill or mutilate themselves, seek oblivion in drink or drugs, sometimes lose their children into care as a result, suffer frightening hallucinations, have endless nightmares and flashbacks, or chronic physical pain, are not feeling OK. They are also trying to tell us something, and it is hard to imagine what more they have to do. As one experienced CSA counsellor remarked with regards to the clients that came forward for this work: *“Survivors don’t talk about the can of worms, because for them it’s already open and they’re in the middle of it”*.

You Want a Witness?

Telling it as it is

| | | | |
|------------|---------------|----------|-----------|
| Would you | the pain | If | I am |
| listen | is constant | I | sick |
| if I | that it | told | of |
| really | interferes | you | surviving |
| told | that it | I | Now |
| you | destroys | was | I |
| what | concentration | afraid | will |
| it's | Or | of | tell |
| like | would | sleep | you |
| Could | you | of | the |
| you | say | my | terror |
| cope | I | body | the |
| if I | can't | or | sickness |
| said | hear | would | are |
| there is | the | you | always |
| no | pain | say | with |
| happy | Tell | I | me |
| endings | me | can't | I |
| Only death | about | you | just |
| Would you | your | are | hide |
| listen | strength | a | it |
| if I said | Would | survivor | because |
| | you | Listen | others |
| | listen | now | want |
| | | | happy |
| | | | endings |

Rebecca Mott

With grateful thanks to Malone, C., Farthing, L., & Marce, L. (Eds) 1996.
The Memory Bird: Survivors of Sexual Abuse. London, Virago

Don't forget the positives!

It is important to understand the range of possible effects of child sexual abuse discussed in this chapter. This understanding encourages empathy, but it inevitably gives a very negative picture. All staff and volunteers need to remember that survivors of sexual abuse have particular strengths and resilience. These strengths can be built upon in any support work. Survivors are essential allies in their own recovery, in the training of professionals, in informing service provision and service delivery, in issues of criminal justice, and in campaigns to reduce sexual abuse in the wider society.

- ▶ Survivors have used great resourcefulness as children and teenagers, often for many years, to find ways of enduring, escaping or reporting their ordeal.
- ▶ They have shown great courage and endurance to survive severe, often prolonged, sexual, physical and emotional trauma.
- ▶ Survivors have detailed knowledge and experience about the patterns of behaviour of their own abusers.
- ▶ Survivors are often incredibly perceptive about signals given off by others, and the motivations, intentions and qualities of others.

How do services respond?

This chapter has described ways in which CSA is a risk factor for a range of life problems. Relevant services, such as those working with drug misuse, homelessness or self-harm, are already building in ways of exploring for the problem, or train and support their staff to work with it. It is important to strengthen this.

It is important to address symptoms, and some service users will, in any case, wish to do no more than that. It is also important, when appropriate, to tackle the underlying causes as this might prove less costly and more effective. It is also important to address survivors' complaints that for years no-one actually asked them what was wrong.

The next chapter explores the barriers to strengthening services' responses. These include: silence among survivors; assumptions and anxieties among workers; and staff not expecting that they should have to deal with the mental health consequences of CSA, and the limitations staff themselves impose on what they can deal with.

There are many barriers, for survivors and those who work with them, to broaching the issue of a sexual abuse history – even if people wish to do so. This has a range of repercussions. For instance, it means many services and projects do not collect basic data on how many survivors use their service; what their needs are; and how best to provide support.

Survivors

There are lots of different feelings and reactions that survivors may have that prevent them telling, or make it hard for them to tell. These may include:

| | |
|-------------------------|---|
| Shame | › They may feel ashamed of what happened to them, or ashamed about people knowing |
| Guilt/self-blame | › They may feel that they were responsible and should, or could, have stopped it; they may feel it’s their fault, that they were to blame for the abuse |
| Embarrassment | › They may feel very uncomfortable about what happened to them |
| Fear | › They may be afraid of the abuser, may have been threatened never to tell, or be afraid of breaking up their family; the abuser may say that the survivor was implicated in illegal activities and could face jail; they may fear being seen as a potential abuser of their children |
| Low self-esteem | › They may feel worthless and of no value |

| | |
|---|--|
| Inability to trust | › They may have great difficulty trusting because they have been betrayed, often by someone close to them |
| Shame and confusion if they responded erotically to the abuse | › If their natural physical response to abuse was pleasurable this adds to their feeling ashamed, uncomfortable and confused |
| May not be believed | › They may not expect to be believed, or may have experienced disbelief |
| Helplessness | › They may feel they have no power or control over their lives |
| Numbness | › They may have cut off their feelings for short or long periods |
| Grief | › They may feel tremendous loss but may not be clear what this is about |
| Shock | › They may be unable to think clearly |
| Don't care | › They may feel 'past caring' and might not look after themselves, their body, clothes or environment |
| Stigma | › They might worry that some people would look on them as 'soiled goods', or as unable to do their job properly, because of perceived emotional damage |
| Feeling dirty | › They may themselves feel soiled, or that their bodies are in some way contaminated |
| Confusion | › They may feel unable to understand their emotions, or to remember clearly |
| Sadness | › They may feel a great sense of loss and may cry a lot, without making the connection with the sexual abuse |
| Anger/disillusionment | › They may feel angry with themselves and with others for not helping them, or disillusioned if past attempts to help never succeeded |

Barriers for staff and volunteers

Numerous reasons for reluctance to raise, or discuss, sexual abuse with service-users have been given, including:

- › Survivors' claims of abuse may not be true, or might be part of their illness
- › We might encourage false memories – see the section below on Recovered and False Memories
- › We don't have enough skills, knowledge or training
- › We don't have the resources or staffing
- › Not part of our work remit; we're not funded for this; it's not on our list of outcomes
- › The person would break down/self-harm/destabilise/become much more distressed if it was mentioned
- › We've been trained not to go there, that it would do more harm than good
- › They might commit suicide and we could be sued
- › He/she has been assessed as too vulnerable
- › Not 'proper' psychiatry: "we deal with severe and enduring mental illness"
- › No one has proved CSA causes mental illness: there are many other influencing factors
- › No treatment shown to work; no evidence base; not sure it's helpful
- › She's always talking about it, but I think it's attention-seeking
- › It would involve lengthy counselling/therapy and we don't have the time
- › Government policy is to move people quickly out of inpatient care – patients would have to stay longer
- › It's not the right time to start now, another time would be better
- › The physical environment here isn't suitable/isn't private enough

- › There's no competent service to refer them on to, so it wouldn't be fair
- › It's not really that serious – not much happened – wouldn't it be more damaging to make a fuss?
- › It's better 'to put the past behind you'
- › People will only tell us when they're ready to
- › Questions would be intrusive, harming my relationship with the client
- › We don't want to trigger child protection guidelines and start a chain of events which could involve police, judiciary and/or court appearances
- › We don't want to trigger child protection guidelines because of the clients' previous bad experiences with the child protection system (especially for young people)
- › Opening the can of worms in small communities is a big step because the abuser might prove to be your patient, friend, colleague, boss or a relative
- › There is no support and supervision available
- › Sexual abuse is so common that if we started a service we'd be overwhelmed

Additional reasons for not wanting to raise the topic of sexual abuse with service-users include:

- › Feeling embarrassed, or awkward, about dealing with CSA, or with sexual matters generally
- › Unresolved personal issues, e.g. unaddressed history of abuse
- › Being involved in sexual abuse oneself; either alone, or as part of a group or sex ring

'Recovered' and 'false' memories

There has been a great deal of debate around the question of 'false' and 'recovered' memories with respect to childhood sexual abuse. Staff have reported this as one reason for reluctance to enquire about possible abusive experiences.

The phrase 'recovered memories' refers to memories of events which have been lost to conscious recall over a period of time, and are subsequently remembered. There is a large international research literature on issues of traumatic memory and traumatic amnesia, not simply in relation to childhood sexual abuse, but to many other traumatic events. You may wish to read some of this literature and some of the debate, and decide for yourself where the most informed, accurate and scholarly opinion lies.

There have been occasions when some therapists working with regression or suggestion techniques may have inadvertently created memories of things which did not happen, resulting in false memories, and in some cases in the prosecution of innocent individuals. Such techniques would not be used by frontline staff anyway and if in doubt you should seek skilled supervision and advice.

We know that there can be many different causes for any particular set of problems a survivor might experience and that we should not make instant assumptions about the cause of these problems. Memory is sometimes unreliable, inaccurate or confused, and can sometimes be influenced by suggestion – this can be true for anyone. Some people without clear memories of the past are also able to make significant improvements in their lives. Having said that, we should not let these caveats stand in the way of offering appropriate help. Part of being client-centred in the work we do is to be guided by and sensitive to clients' individual needs.

It is helpful to remember the following:

- › Many people who disclose a history of sexual abuse will not have lost it to conscious recall at any point in their lives, and the question of ‘recovered’ memories will not be an issue.
- › It is good practice routinely to give clients the opportunity to talk about their past experiences by asking simple, diplomatic questions, as suggested in chapter 3. There is no evidence that this can trigger or create false memories.
- › There is no evidence that listening sympathetically and supportively to a client who wants to talk about the details of their experiences will create false memories.
- › People may find it upsetting where memories of abusive experiences emerge during any type of work or support and may not be sure themselves whether the recovered memories are true. It may be helpful to focus on supporting the client in tolerating the ambiguity of the situation they find themselves in, and on reducing their distress. It is important to seek skilled supervision and advice.

What is helpful to overcome the barriers?

Reading through this chapter, we might wonder how the issue is ever addressed at all! Considering the barriers to disclosure and discussion for survivors, staff and volunteers, it is not surprising that after decades of publicity, there still remains a problem about “breaking the silence” when it comes to sexual abuse.

Do abuse survivors confirm the beliefs and anxieties listed, or not? What do they say they find helpful in staff, or volunteers, who work with them? The next chapter considers some of these questions.

Through many years of talking and carrying out research with survivors of childhood sexual abuse, we have found there is a strong consensus about the kinds of people and services they value as most helpful.

These are a few of the major points survivors have made:

› **Help us to tell**

Many survivors, for reasons already discussed, find it very difficult to raise, or discuss, their own history of abuse. This does not mean that survivors do not want to be asked, or to be offered an encouraging atmosphere for disclosure. Indeed, many have been sending out signals since their childhood in the sometimes desperate hope that these will be picked up and acted on. If professionals keep waiting for clients “to be ready”, they may wait forever.

Most of the survivors we have met have been much more frustrated and upset about *not* having abuse issues recognised or dealt with (often for decades), than with having the issues raised. The failure of many services to accurately perceive their distress was a huge problem for most survivors in the *Beyond Trauma* study.

“It wouldn’t have mattered if I’d been in a coal cellar (instead of the psychiatric ward), so long as there was someone to help me, and to listen. If you had a trained counsellor or psychiatrist who was prepared to listen, instead of asking all the time, what are you thinking? Someone without a time limit on them; someone who’s not going to patronise you.”

In fact, it is so rare to meet an adult survivor who expresses concern about being asked sympathetically and sensitively about a possible history of abuse, that it's difficult to figure out where this preconception comes from. In some countries, such as the USA, questions about childhood trauma are included much more often by medical or psychiatric professionals in questionnaires, and inventories on physical or mental health. No major problems of acceptability appear to have been uncovered through this practice. Some professionals in this country also routinely explore for possible abuse issues. For instance, more than 80 patients within the space of about two years revealed an abuse history to former Scottish GP Dr Willie Angus, who has written about the issue for GPs in the *British Medical Journal*⁴ and about the symptom relief which occurred for many patients. He told *health in mind*:

“I was never criticised by patients for asking them if they had suffered from abuse, or were sexually abused as children. I see no reason why, in suitable circumstances, the question cannot be sympathetically addressed to anyone ... those to whom it did not apply seemed undisturbed and answered in the negative. Most survivors were considerably relieved when the question was asked as they had, in many cases, tried to bring up the subject but felt unable to do so in case they were disbelieved or rejected.”

Ways of asking: Some survivors appreciate being asked directly, others less boldly. If staff and volunteers don't feel comfortable asking the question outright, a range of diplomatic approaches and styles for building the issue into assessment procedures is possible, especially within broader questions about problems in childhood. Projects can also consult each other on what wording they have found helpful.

For instance, doctors at one Edinburgh practice where many survivors had come forward explained: *“We might say, ‘Depression is often related to stresses in a person’s life. There might be current things, or*

⁴ Angus, W. The Patient who Changed My Life 1996 *British Medical Journal*, July, 313:210

things that happened in the past, that are still causing you pain...do you think there could be problems from your childhood?' Or we might say, 'Has anyone done anything to you that you wish they hadn't?' or, 'Was anyone horrible to you as a child?'"

A male survivor recalled: *"I couldn't bring myself to say at that time. Well, after a while my CPN (community psychiatric nurse) just handed me a leaflet (for abuse survivors' project he now regularly attends) and said, matter of factly, 'I wonder if that might be any use to you?' And just left me with it so as not to embarrass me..."*

One female survivor recalled: *"I still say that [a fellow survivor] saved my life. We had known each other from way back. I was sitting drinking as usual and she arrives and says 'Hi, how you doin?', and then I remember her saying 'I was abused when I was a bairn. 'And I said,' So was I!' And she just let me go on and talk about it for hours. And that enabled me to tell my keyworker..."*

► **Please don't assume we're too vulnerable!**

There is nothing worse for survivors than to be treated by staff in ways that reinforce their previous experiences of rejection. Yet survivors report that staff frequently fall into this trap, leading to a retraumatisation for them as they struggle with issues of blame, responsibility and power. The very fact they are survivors is testament to their resourcefulness and resilience in the face of extreme events that have happened to them.

Despite what may be the best of intentions of service providers in assessing clients for different therapeutic approaches, it can be very difficult for survivors to be told they are not suitable or that the treatment is not appropriate.

*"I sat for two hours answering questions ... at the end of it he said, 'I don't think you're suitable.' I said, 'I beg your pardon?' He said, 'I don't think you're suitable for psychotherapy ... don't you think it would upset you too much?' I just thought, 'Rejected because I'd be upset? That's why I'm here, to speak to someone because I'm f***ing upset!' "*

“Well they put me out. They told me I wasn’t right for them and that I wasn’t to come there. I remember it (the assessment) only went on for about 15 minutes and it was like, cheerio! I had to circle things and I think they thought I wasn’t right for them!”

› **Survivors value all kinds of time....**

Many staff believe that you have to devote huge amounts of time to listening or responding to survivors, and that because their service can’t provide this time, they feel it’s better not to start. One problem is that every service a survivor passes through may take this view, so that they never actually receive the attention they need! Survivors do not themselves support this view: they value many opportunities to talk in different situations and settings, and all of these can be helpful.

Do not make assumptions: consult with survivors. While some do need and welcome long-term work many do not, or do not require it at this moment. Some will only want to tell their story once, and that is enough.

One exasperated psychiatric patient explained, after endlessly being asked unimportant details about her history but never about her abuse history:

“I’m a survivor. I want acknowledgement, receptivity and understanding. I just want someone to sit over there and listen to me ...I need my story to be witnessed, and that’s the validation I’m looking for.”

What survivors do value are open-ended services, which they can dip into according to need (or repeat, in the case of a set programme). They can find it very frustrating if the few services available only offer six or ten sessions, expecting survivors to feel better in that time! Just as the effects of trauma are unpredictable, so are the times when people need help: *“A drop-in service, or services you can keep*

returning to if you want, without a cut-off point. It's important just to know somebody's there: it doesn't mean you have to use them."

Nor should small amounts of time ever be devalued. Survivors repeatedly recall staff, volunteers, friends and family who were catalysts to changing their lives through brief interventions – perceiving the problem, taking a few minutes to listen or talk, suggesting something helpful, or being flexible enough to offer help at a vital moment. None of these helpful actions were, to use the jargon, 'rocket science'.

For example:

- › A night nurse who talked to one very distressed pregnant survivor and gave her the courage to stop drinking in order to keep her baby.
- › A night nurse who sat with a severe self-harmer, and explained that all the other staff were being horrible to her because they couldn't cope with the self-harm.
- › A surgeon who spent 40 minutes before an operation reassuring a survivor whose experiences caused terror of medical procedures, and a physiotherapist who sat with her during treatment on a machine, to prevent her from dissociating and 'freaking out'; *She would sit with me and talk about anything to keep my mind back on planet Earth."*
- › A fellow survivor who sensed her friend's life was at a dangerous point, and took her to her house where she confessed her own history of abuse. That led the friend to admit abuse for the first time and to phone her hospital counsellor. This nurse, sensing the importance of the moment, let her come and talk immediately, even though the client had been drinking heavily.
- › A GP, puzzled by an old woman's conviction that she had a sexually transmitted disease, thinking to ask: "*Was anyone horrible to you as a child?*" She said, '*Yes, my father and brother*'; and it all came out. *She felt she had wasted her whole life."*

- ▶ **We're not looking for great experts, we want a human being...**
Many staff and volunteers feel huge inadequacy about working with sexual abuse and believe they need higher qualifications and lengthy training. But that belief is not supported by research, or by discussion with survivors themselves. Appropriate and focused training is important, but there are other important factors as well. In the *Beyond Trauma* study there was so much consensus about characteristics of the most helpful workers (see Summary, below) that we were able to draw up a pen picture, as well as interview some of the people they named. Helpful workers came from all professions and degrees of status, or qualification. They were skilful, "low-tech", imaginative and client-centred, but they also used simple, human ways of communicating and were modest and genuinely committed. Many of the typical qualities come through in this quote from one nurse who was named by survivors:

"I've not done special training, I've just been a nurse and worked with people. I've done the reading myself – I just feel it's my job to contain people's emotions, to show that I'm not horrified. I'm not going to rush from the room to get a tablet. I believe I should let them talk – I don't have a (formal) structure as such, apart from that. It's a two-way thing, asking people if they want to talk about that (e.g. something that came up yesterday) or leave it for now...."

It can be really dramatic sometimes. I once saw a woman almost go back to when she was a child in the bedroom, the terror, breathing etc I wasn't sure what to do, so I just talked her down. I acknowledged what was happening ... I held her hand and talked to her."

Survivors do not mind if helpers confess that they don't know something, or still have things to learn. Nor do they mind if a support person shows some sympathetic emotion. Survivors don't want to work with a cold and impassive listener nor, in contrast, do they want to work with someone who breaks down and is unable to continue. As one survivor who had disappointing experiences with many professionals recalled:

“My CPN (community psychiatric nurse) was the first person to show emotion when I told her about some of those terrible things. I was touched by this. A few days later she confessed to me, ‘I feel I’m not experienced enough to be able to see you and talk to you. The last time (we spoke) you were on my mind for four days, even at home, and I saw my superior about it and she would like me to stay on with you and I would like (that). But I just want you to know I don’t have the experience...’ Well I appreciated that ... it ended up that I was getting the names of books on sexual abuse over the internet for her to read!”

Summary:

Whom do survivors find most helpful?

In the *Beyond Trauma* research, professional status, qualifications, and theoretical approaches emerged as much less important for survivors than the qualities listed below. The most helpful person:

- › Is secure about boundaries, but relates with warmth and kindness
- › Is informed and aware about CSA, or keen to learn
- › Has examined his/her own issues around CSA
- › Works non-hierarchically, consults clients, reaches joint decisions
- › Is client-centred, flexible, imaginative
- › Neither hides behind confidentiality, nor breaks it insensitively

- › Has courage to stay with clients through distressing details or behaviour
- › Is prepared to work over a period of time, though brief contacts can sometimes be the catalyst to life changes.

Survivors also valued being offered a **choice of gender** in the worker.

It is interesting that there were many similarities between these recent findings and the findings of other published research on therapist-client variables, such as that summarised by Peter Dale in his book *Adults Abused as Children*⁵. Positive outcomes for clients were consistently more closely associated with the personal characteristics of therapists, than with therapeutic orientation or techniques. There were other similarities in the characteristics perceived as being most helpful by clients:

- › Personal warmth and likeability
- › A non-judgmental attitude
- › Being empathetic, accepting, objective, patient and understanding
- › Demonstrating genuine interest in the client.

The next chapter suggests ways in which staff and volunteers can put some of these points into practice (and avoid some pitfalls) when talking and working with survivors.

⁵ Dale, P. (1999) *Adults Abused as Children* London, Sage

Drawing on the information already discussed in this booklet, we summarise what we believe are some of the most important ways you can help, support and work with survivors of childhood sexual abuse. We can only repeat that these are not superhuman qualities and skills, but basic human ones. No-one should be afraid of learning to use them.

Facilitating disclosure, setting the environment, ‘tuning in’ to the right signals

Because of their experience of sexual abuse, and the resulting difficulty in trusting others, many survivors are very sensitive to how people react. They have an acute ability to tune in to others, and can sense if workers are able, available, and willing to go the course with them. The survivor picks up on our verbal and non-verbal cues, and decides whether they can trust us enough to disclose. Workers, in turn, send out messages about how comfortable they are. So the reactions of workers to disclosure (or even the impression they give when survivors are considering disclosure) can determine whether that survivor is able to seek further help to begin the process of healing. If handled badly, it will hinder further discussion.

As we have seen, the reluctance people can feel about working with survivors is often because of a fear of harming them, of saying the wrong thing, or of making things worse. But what survivors need is to be able to talk and to receive good practice. A lot of what is required is simply about you as a person: how you are with the survivor; your personal approach, warmth and acceptance. These are far more important than detailed knowledge and training, although it is important to remember that those working with clients with moderate to severe mental health problems associated with sexual abuse should also have adequate training.

Workers need to feel confident about the skills, abilities and personal qualities they can offer which help to create a safe environment in which discussion of sexual abuse can take place. Your understanding, warmth and acceptance are of the utmost importance in establishing trust. It is also important to have some knowledge about sexual abuse. Training is an enormously helpful way to feel more confident about your ability to deal with sexual abuse and is essential to improve your knowledge and awareness.

It is also important that you explore your own history in relation to abuse, so that your own things do not get in the way. For instance, if you are yourself a survivor (as many professionals will be), this can prove a great source of understanding, skills and experience. But you also need to be sure you feel in a strong enough place at the moment, that you have the support you need to do this stressful work, and that you do not try to resolve unaddressed issues of your own through other survivors. To take another example, if you, or someone close to you, has been wrongly suspected of child abuse, you need to ensure your understandably angry feelings do not affect your perception of the credibility, or good faith, of the survivors with whom you work.

Being open to the possibility of CSA also means having leaflets, books, and posters around your workplace; anything that could make it easier for survivors to identify themselves. It might be part of your routine assessment procedure, or could be mentioned sensitively as a possibility as you work with people, such as asking 'Did anyone hurt you when you were a child?'. It is important that people know that you are offering the opportunity to tell you if they want to, and that you are ready if, and when, they choose to talk. For those who are uncertain, it is helpful to tactfully and sensitively be aware of the signals you may be offered, and to respond positively, conveying your willingness to work alongside them wherever that may go.

Have faith in your own strengths

People often react fearfully to the prospect of someone revealing sexual abuse, almost as if the survivor (or even the entire room) might spontaneously combust! If a survivor chooses you to confide in for the first time – in whatever setting and for whatever reason – they may well become distressed or tearful (even with relief). But this is natural. If you are an empathetic person and skilled listener, and especially if you work in a caring profession and often encounter distressed people, you would be able to cope with a newly-bereaved person, with someone whose child is seriously ill, someone crying with shock after a road accident or many other situations. There's no reason for fear of this disclosure or distress: just use the same skills, personal warmth and means of comfort that you would normally use.

Acceptance

It is important that you accept the survivor and what they may tell you: that they feel valued and respected for their courage in disclosing, and for what they have endured. The acceptance of an understanding other can break through low self-esteem and worthlessness. Your consistent acceptance, conveyed with warmth, (not just the words you may use but your whole approach, your gestures and tone) if genuinely meant, will affirm the survivors' worth and help them feel they are not judged. This will help them to accept themselves (maybe for the first time in their lives). This is both strengthening and freeing, and can enable them to go further.

Belief

Often the survivor will feel that they won't be believed, or they may have tried to disclose previously and been met with disbelief. This reaction perpetuates the cycle of abuse, and maintains the silence that they are attempting to break. When survivors disclose it can be so horrific that it is hard to believe, but this is not a reason to disbelieve and it may be necessary to 'suspend disbelief'. As listeners,

staff are there to validate and listen to what they are being told. It is important to remember that it is not up to you to judge whether precise details of the content are true, or accurately recalled, but rather you should respond respectfully to what is said. The circumstances where this *is* important (e.g. in a court case) will fall within the remit of other professionals (for instance, police officers investigating a crime.) Where there are child protection issues there are limitations of confidentiality, see Appendix Three, pages 64 to 66 for guidance on this.

Understanding

For someone to be understood accurately in what they are saying is enormously important – it helps survivors feel they are no longer isolated or alone with this.

Respect and dignity

Survivors have generally not felt they have any power or control in their lives and many consequently have low self-esteem. Survivors have the right to be treated with respect and dignity, and to feel that they are worthy of this. This means respecting the choices survivors want to make about their recovery, and respecting their values. It includes examining your own beliefs (religious or any other kind) and making sure they don't negatively affect your perception of the worth of the person you are supporting. Nor should you impose your beliefs on the person you are supporting.

Being genuine

You need to be honest with the survivor. They would rather you told them if you do not know, or do not understand what they say to you. Responding humanely and being genuine helps. If you can tell them you're not perfect, then they too can feel OK about being genuine. Survivors value human reactions: it's alright to show you are shocked at something survivors may tell you, as long as your own fears don't take the focus away from the survivor or make them feel they have to protect you from further distress.

Going at their pace

It is very important to respect the time this can take. Each person has their own way of dealing with abuse and a need to go at their own pace. There may be times when this is slow, or they may need to take breaks and return when they feel able. Keeping the door open and maintaining trust that they will not be pushed is vital to being able to finish the work.

Men in our society are expected to be strong and in control, to be macho, not to be vulnerable or victims. These stereotypes can keep men silent about their abuse. This needs to be taken into consideration when working with males, as it can mean it can take longer to disclose, that there can be a great deal of shame for men around disclosure, and there can be the added fear that they will be thought of as homosexual if they are heterosexual, or that they will face homophobia if they are gay.

Anticipating and planning for temporarily increased distress

Although most survivors feel relieved to address their abuse issues, often after decades of silence, it is also true that they can often experience worsening of distress symptoms in the short term. This is natural and to be expected: it is a feature of work with other kinds of trauma too, and is not a reason to stay stuck behind the starting-blocks. But it does mean that you need to plan, in consultation with the survivor, some extra support during that time, and also some self-help resources, which they may need to help deal with issues like panic attacks or dissociation.

If you are someone who works with survivors in the medium and longer term, this planning is also important for other crises, or for temporary setbacks, because progress is rarely linear and straightforward. Extra support can take many forms. To give one example, SAMH's Redhall Walled Garden Project in Edinburgh (not a

CSA project, but one which many survivors have found valuable) described how helpful it could be if people who were going through distressing material with a counsellor in the morning could find support and space in the peaceful setting of the garden in the afternoon.

Being able to stay with them

Because of the nature of abuse, it can be very painful and frightening for a survivor to talk about their experiences in detail. They need you to be able to listen to them, and to reassure them that you will stick with them whatever they tell you, no matter how hard. If you leave because you are unable to face what they are telling you, you will simply be reinforcing their negative feelings about themselves and the perceived hopelessness of their situation. It is also important that you have adequate personal and professional support if you are listening to graphic and distressing material.

Validating their anger

It is important that survivors' anger at the abuser is expressed, heard, and seen as a natural, healthy response.

Taking their health seriously

Many survivors have physical health problems as a result of their past abuse, or their lifestyle following abuse. They may also have injuries, or infections, relating to more recent sexual assault. Often part of not valuing themselves is not valuing their right to good health. Make sure that you do. Take their problems seriously. Encourage them to get health checks, and be prepared to talk over their fears of doing so. Let them know if you are aware of particularly sympathetic and understanding services, or medical professionals.

Support and supervision

We have emphasised throughout this booklet that asking tactfully about a CSA history, or responding constructively to initial disclosures, does not have to be frightening for workers. Many survivors will feel great relief and will not wish to go further than having their history acknowledged, explaining what needs they would like to follow up on, or discussing with you what other agencies could offer particular support and advice. You may, however, be someone who works regularly and in more depth with survivors on their abuse issues, or someone whose job could involve hearing, at any time, painful and difficult revelations. If so, it is essential that you have regular supervision; either within your organisation, or from an external supervisor.

This work is hard, and can be very emotionally demanding as survivors are often remembering distressing childhood memories which can be very frightening for them, or recalling the emotional reactions they had at the time of the abuse, which can be equally gruelling. You will require support and supervision to be able to work effectively, and intimately, through very challenging and difficult histories, with people who are very often on the edge. Working with this level of fragility cannot help but touch you emotionally.

For you to be able to remain in close contact with the survivor (which is what is required), you cannot afford to hold this on your own. If you are unsupported, you will risk failing the survivor; there is a risk of vicarious traumatisation and identification with the survivor, where you become less helpful as a result of experiencing some similar feelings to the survivor themselves and, as a result, seeing things from a limited perspective. We cannot emphasise enough that, throughout this process, it is essential that you, like the survivor, have a safe place to go to discuss the work confidentially, to offload your feelings, and receive ongoing, consistent support. The form that the support takes needs to be one-to-one supervision, peer supervision, or both.

It is worth noting here that it is an ethical requirement for all professional counsellors to have adequate regular supervision, with

the level based on the number of clients and intensity of work undertaken. This requirement clearly recognises the level of complexity involved in such work. Although not all workers are necessarily trained counsellors, many are fulfilling a similar task. Although we are not saying they have to meet exactly the same requirements, your organisation needs to see adequate supervision support as a pre-requisite for undertaking medium to longer-term work with survivors of child sexual abuse.

Your manager or senior in your organisation should ensure that you have adequate supervision and support in place for dealing with child sexual abuse. It is also important that local authorities and health boards, who commission such services, build in funding for adequate supervision. Workers who are dealing with stressful client-work, such as this, have the right to demand adequate supervision from an appropriate person, as the organisation has a responsibility to protect staff from work-related stress. Adequate supervision time focused on the client-work, rather than the line management issues, is a helpful way to monitor and assess the impact of the work on staff, and to make sure that everyone is OK. Proper supervision helps ensure that the survivor, as well as the worker, is supported.

...Don't forget to ask two simple questions!

Finally – in the midst of trying to follow all the advice in this chapter, and turning into a superhuman (or just human!) being – check that you haven't forgotten actually to consult the survivor on two very practical questions:

- › “What problems, if any, do YOU think the abuse has left you with?”
- › “What are the main things YOU would welcome help with now?”

These questions are an essential part of planning for the kinds of support and interventions – if any – which survivors might need in the short, medium and the longer term. The final chapter makes a few important considerations about that process.

This booklet concentrates on the initial and early stages of work with survivors of sexual abuse. It also focuses on basic principles of working in one-to-one situations with survivors: how can their underlying problems be better identified? How can you become more confident to ask tactful questions and offer support? How can the working environment and personal approach help survivors talk safely and freely about abuse issues? We have, so far, concentrated on ways of building and maintaining the one-to-one relationship because that is such an essential part of achieving those aims.

But, of course, this does not imply that continuing one-to-one work involving the survivor and one support person, or support agency, is the only, or necessarily the best, way of working with that survivor. Nor does it imply that any particular counselling, therapeutic, or ‘talking treatment’ approach, is superior to any other means of giving support, achieving change or tackling sexual abuse.

Talking with, and listening to survivors, makes us aware how varied their problems can be, how these problems are often practical as well as emotional, how many different agencies may have valuable assistance to offer, and how important it can be to consider help that may be needed for their wider family and social networks. Working with the ‘whole person’ means taking into account all aspects of their lives that may have been touched by the effects of the abuse, including their family and social relationships, their education and work, their health, and a range of possibly unaddressed concerns – for instance their concern for justice for themselves, and for other adults and children who have suffered abuse.

Consultation with survivors always helps support plans

“Nobody ever asked me what I wanted.”

(Client who spent more than 15 years in and out of psychiatric care)

One clear lesson that emerged from the *Beyond Trauma* study was that, apart from one extremely distressed and damaged teenager, every woman interviewed, despite her mental distress, was able to describe clearly the main problems the abuse had caused for her, or her children, which she wanted to be addressed. Most of the women had rarely been asked this question before, and some never. The examples below show just how diverse the problems they identified were. They include major issues, such as justice and protection. Their responses offered many pointers to the (often practical) assistance women needed. Their examples also demonstrate to workers reading this booklet that, when survivors are consulted, it becomes much easier to see which agencies might be helpful to them and to other important people in their lives. Examples included:

- › Legal advice for the survivors, or their children, especially on taking cases to court.
- › Stronger action by police and social workers to protect known children, whom the survivors believed to be at risk.
- › Help to access medical and social work records, which would piece together distressing, confusing “memory blanks” about their childhood.
- › Help to find accommodation which was safe, secure and confidential.

- › Counselling focussed on their feelings of bereavement and loss about teenage miscarriages and forced abortions.
- › Agency mediation, or advice, to repair fractured relationships with their adult siblings, their mothers, their partners or their own children.
- › Practical and emotional support for their (non-abusing) partners.
- › Specific treatment to reduce intrusive thoughts and the ‘voice in the head’ of the abuser.
- › Conventional, alternative or complementary therapies for debilitating physical health problems.
- › Help with literacy problems caused by emotional ‘blocking’ in their childhood, which hampered efforts at learning, work or training.
- › 24-hour survivors’ helpline to cope with frequent suicidal feelings.
- › Specific help to reduce overwhelming fears of leaving young children with any babysitter, crèche or nursery.
- › Practical childcare support for mothers, including accessible, safe childcare projects in their own communities, when they were suffering depression and could not fulfil their usual responsibilities to their children.

Consulting people in this way by asking, “What problems do you think the abuse is still causing for you *now*?” “What issues would you like help with *now*?” does not stop professionals using their own skills and judgment as part of that assessment. But it does mean survivors’ own judgments and views need to be an essential part of support planning – including multi-agency planning – for both the present and the future.

The cost of ignoring the survivor

Overlooking this can at best be futile, and at worst can have serious consequences for the survivor and his/her family. For instance, elaborate multi-agency plans involving social work, addiction agencies, children's reporters and psychiatric services may be drawn up for a mentally distressed, substance-abusing woman and her children. If these fail to understand, or address, underlying abuse issues, or the woman's priority needs, these can simply prove a waste of time and money.

One example from the *Beyond Trauma* research concerned a mother who was viewed very negatively by a range of statutory agencies, whose children went in and out of care, and for whom many (largely unsuccessful) multi-agency plans had been attempted. She eventually managed to tell the research interviewers the reason why she rejected her son: her own brother had started abusing her at her son's age. She felt continually terrified for the safety of her young daughter. Sympathetic listening and talking about the abuse issues might have drawn this information out sooner, and relevant strategies might have been developed to address what had become a very damaging problem for her children and herself.

Services which should consider checking routinely for a CSA history

Sometimes, the need to consider abuse issues in planning for people's needs and addressing their problems is especially urgent. We believe that the managers, directors and commissioners of services should seriously consider the stage when this ought to become a point of policy. In certain services, where a history of abuse may be having a strong influence on desperate, dangerous, very distressed or chaotic behaviour, and where unaddressed abuse may result in further risk to self or others, we believe that exploring for a possible history of

sexual abuse **should be included in the routine assessment process**. At present this does not happen often enough. It need not take the form of a blunt question, nor need it take place at immediate contact by the client with the service: it can be a tactful exploration of the issue over the early phases of a person's contact with services.

The reason why this is a topic for managers, directors and commissioners is that, as with support and supervision issues (see chapter 4), they alone may be in a position to create and enforce changes in practice.

We suggest that the routine exploration of an abuse history should be considered as a priority in services dealing with:

- › Acute psychiatric admissions
- › Chronic mental distress and 'treatment-resistant' mental illnesses
- › Personality disorders
- › Forensic psychiatry and work in Special Hospitals
- › Attempted suicide
- › Persistent self-harm
- › Heavy substance misuse
- › Serious and persistent offending
- › Homelessness
- › People with several unexplained, chronic physical health problems
- › All services dealing with disturbed behaviour (including eating disorders) in young people under 18, where there may also be important child protection issues involved.

SUMMARY OF KEY POINTS

- ▶ *Child sexual abuse takes many forms, and has a wide range of effects.*
- ▶ *Not all survivors will be suffering and in pain – many do manage to turn their distress into personal strengths, and live happy and successful lives.*
- ▶ *However, many survivors face serious physical or mental distress. It is not helpful to assume that they are somehow ‘all right’ if we ignore the issue, or that addressing the issue will make them ‘worse’.*
- ▶ *Currently, many workers across a range of services fail to see, or ask about, the underlying cause of the distress, only dealing with the symptoms.*
- ▶ *Many factors can hinder survivors who want to talk about their sexual abuse. These include individual factors such as fear, stigma and embarrassment, as well as external factors, such as workers not picking up on cues or hints, not believing survivors’ stories, believing that they need special training, believing that it would do more harm than good to speak about the abuse, and feeling embarrassed or uncomfortable. Lengthy training is not necessary for dealing with initial disclosures, since this is about the role of empathic listener. It is required, however, for working with moderate to severe mental health problems associated with sexual abuse, such as dissociation, Post Traumatic Stress flashbacks, ‘personality disorder’ diagnoses, psychotic episodes.*
- ▶ *Talking about sexual abuse, like talking about suicide, DOES NOT make things worse – it is an essential step on the road to healing. It is important though, to try to ensure that the service user has support outside the service, as survivors may experience a worsening of distress symptoms in the short term.*

- *You CAN help survivors by making opportunities for people in distress to disclose sexual abuse where this has happened to them. It might be part of your routine assessment procedure or could be mentioned sensitively, such as asking, “Did anyone hurt you when you were a child?”*
- *Remember that while some survivors may need years of intensive support, others may have much more defined and limited needs.*
- *When you are discussing sexual abuse with survivors, including longer-term support planning, always ask how they see their own needs, and what would be helpful for them.*
- *Basic human skills and characteristics, such as empathy, trust, understanding and respect, are the most important qualities in working with survivors.*
- *Be flexible in approach but secure about boundaries. Keep to agreed meetings, don’t overstep your personal limits, be consistent.*
- *Supervision and structured support is essential for any intensive, continuing or longer-term work with survivors, and also if you have been distressed through hearing painful details. If you are a manager, you have a responsibility to make sure your staff or volunteers are adequately supported.*
- *DON’T pass survivors from pillar to post. View other professionals and specialist sexual abuse agencies as additional supports for the survivor, but don’t feel you have to withdraw your own support.*

APPENDIX ONE: National Resources

Thank you for listening! Some useful contacts, addresses and information sources follow. The contacts in this and the following sections were believed correct and had been checked at the time of going to press. However, please bear in mind that organisations' details can quickly change.

If you wish to read further about childhood sexual abuse, its effects, healing and recovery then Directory and Book Services (DABS) has an online bookstore. DABS is a specialist book and information service for people who are overcoming childhood abuse, sexual abuse, or domestic violence, and for those living and working with survivors.

Directory and Book Services
4 New Hill
Conisbrough
Doncaster DN12 3HA
Tel: 01709 860 023
www.dabsbooks.co.uk

Many services and agencies, including survivor websites, will often have their own list of books, journal papers and other resources, tailored to the particular services they offer and the needs of their client group. You may wish to consider these also.

National Resources

www.survivorscotland.org.uk

The Survivor Scotland website has been developed by the Scottish Government to improve the lives of survivors of childhood sexual abuse. It has a wide range of material about abuse, it is a resource for a wide variety of interested people, and it gives useful links to other websites that may also be helpful.

Health in Mind

40 Shandwick place

Edinburgh EH2 4R5

Tel: 0131 225 8508

Fax: 0131 200 0028

Email: contactus@health-in-mind.org.uk

www.health-in-mind.org.uk

Health in mind works across Scotland and offers a range of services including confidential counselling and psychotherapy, emotional and practical support and group-work for adult survivors of childhood sexual abuse, as well as research and specialist training.

Dental fear

www.dentalfearcentral.org

Personality Disorder Network

The Scottish Personality Disorder Network, commissioned by the then Scottish Executive, links interested groups across Scotland in the areas of research, education of the workforce and public and the issues of accessing appropriate treatment. It has contributed to the development of an integrated care pathway for people with borderline personality disorder to ensure that this group gets access to the best possible treatment.

www.scottishpersonalitydisorder.org

Rape Crisis Scotland

Freephone helpline: 08088 01 0302

Rape Crisis Scotland provides a national rape crisis helpline for anyone affected by sexual violence, no matter when or how it happened. The helpline is open from 6pm to midnight, 7 days a week, and offers free and confidential initial and crisis support and information. The helpline can put callers in touch with local rape crisis centres or other services for ongoing support. The helpline offers a minicom service for Deaf or hard of hearing people, and can arrange for language interpreters if your first language is not English.

Roshni

Floor 2

9 Eagle Street

Glasgow G4 9XA

Tel: 0141 433 4343

www.roshni.org.uk

Roshni raises awareness of child abuse within the black and minority ethnic communities, empowers children and young people to talk about and challenge this sensitive issue, and promotes where to access support services to children, young people and adult survivors of abuse.

SAMH

Safe to Say

Central, South and East Regional Office

The Fisherrow Centre

South Street

Musselburgh EH21 6AT

Tel: 0131 665 0843

Fax: 0131 665 3925

Email: sue.hampson@samh.org.uk

SAMH Safe to Say is a National Training for Trainers programme, to deliver best practice training in the quality of responses to adult survivors of child sexual abuse, working with both statutory and voluntary agencies. The team also provides consultancy and frontline and supervision training.

For UK-wide resources and other specialist resources please see the final section of Appendix Two.

APPENDIX TWO: Contact Addresses

Below is a sample of services across Scotland. There are many other valuable services, and this list is in no way intended to be exhaustive, nor should it be taken as a recommendation of any of these services. For a more comprehensive list see the **Register of Services for Scotland on Violence and Abuse**, 2004, which is available from:

**WOMEN'S SUPPORT PROJECT, GRANITE HOUSE,
31 STOCKWELL STREET, GLASGOW G1 4RZ.**

Tel: 0141-552-2221

Email: info@wsproject.demon.co.uk

ABERDEEN

Rape & Abuse Support

46a Union Street

Aberdeen AB10 1BD

Tel : 01224 620 772 (helpline)

Tel : 01224 639 347 (admin)

E: info@rasane.wanadoo.co.uk

www.rapeasbusesupport.org.uk

Support for women and girls who have been raped or sexually abused.

Aberdeen Women's Aid

315 Holburn Street

Aberdeen AB10 7FP

Tel: 01224 591577

E: info@aberdeenwomensaid.co.uk

www.aberdeenwomensaid.com

Support for women and children who are experiencing domestic abuse.

Children 1st

Aberdeen City:

Tel: 01224 251 150

Aberdeenshire:

Tel: 01346 512 733

Therapeutic services for children and young people who have been abused.

AYRSHIRE

Break the Silence

55 Titchfield Street

2 U/L

Kilmarnock KA1 1QS

Tel: 01563 559558

E: breakthesilence@fsmail.net

Support for adult survivors and their partners.

BORDERS

Children 1st

Ettrick Road

Selkirk TD7 5AJ

Tel: 01750 228 92

www.children1st.org.uk

Therapeutic services for children and young people who have been abused.

DUMFRIES & GALLOWAY
South West Rape Crisis & Sexual Abuse Centre

9 George Street Meuse
Dumfries DG1 1HH
Tel: 01387 253113

E: support@swrc.worldonline.co.uk
Support for women who have been raped or sexually abused.

Dumfriesshire & Stewartry
Women's Aid

12 Whitesands
Dumfries DG1 2RR
Tel: 01387 263052

Helpline: 07710 152772 (24-hour)
E: admin@dumfrieswomensaid.org.uk
Support for women who have experienced domestic violence.

DUNDEE
Tayside Ritual Abuse Support and Help (TRASH)

Helpline: 01382 207 667
www.rans.org.uk
Support for people who have experienced ritual abuse.

Dundee Women's Aid

61 Reform Street
Dundee DD1 1SP
Tel: Crisis Line: 01382 202525

Fax Line: 01382 226390
E: dwa@dundeewomensaid.co.uk
www.dundeewomensaid.co.uk
Support for women, young people and children who have experienced domestic abuse.

Women's Rape and Sexual Abuse Centre

PO Box 83
Dundee DD1 4YZ
Tel: 01382 205556 (office)
Helpline: 01382 201 291
Minicom: 01382 226 936
Fax: 01382 205556
E: wrasac@btconnect.com
Support for women who have been raped or sexually abused.

Eighteen and Under

1 Victoria Road
Dundee DD1 1EL
Tel: 01382 206 222
Helpline: 0800 731 4080 (for young people)
E: lormac1053@aol.com
www.18u.org.uk
Confidential support for young people who have experienced any form of abuse.

EDINBURGH**Beyond Trauma Team***Health in mind*

40 Shandwick Place

Edinburgh EH2 4RT

Tel: 0131 225 8508

Fax: 0131 220 0028

E: contactus@health-in-mind.org.ukwww.health-in-mind.org.uk

Offers a range of services, including: confidential counselling and psychotherapy, emotional and practical support and group-work for adult survivors of childhood sexual abuse, as well as research and specialist training.

Edinburgh Women's Rape and Sexual Abuse Centre

PO Box 120

Brunswick Road

Edinburgh EH7 5WX

Helpline: 0131 556 9437

E: EWRASAC@aol.comwww.rapecrisisscotland.org.uk

Support for women who have been raped or sexually abused.

Gay Men's Health

10a Union Street

Edinburgh EH1 3LU

Tel: 0131 558 9444

Fax: 0131 558 9060

E: counselling@gmh.org.ukwww.gmh.org.uk

Counselling for gay and bisexual men.

Saheliya

10 Union Street

Edinburgh EH1 3LU

Tel: 0131 556 9302

Fax: 0131 556 9302

E: saheliya@connectfree.co.uksaheliya.pwp.blueyonder.co.uk

Counselling and support for Black and Minority Ethnic women.

Barnardo's Skylight

27 Ocean Drive

Edinburgh EH6 6JL

Tel: (0131) 561 1464

E: skylight@barnados.org.ukwww.barnados.org.uk

Counselling and support for sexually abused children and young people.

**Child Sexual Abuse (CSA) Team
Child and Adolescent Mental
Health Service (CAMHS)**

Royal Hospital for Sick Children
3 Rillbank Terrace
Edinburgh EH9 1LL
Tel : 0131 536 0574
Fax: 0131 536 0545

www.nhs.lothian.scot.nhs.uk

Therapeutic service for children, young people (up to age 18 years), and their families/carers who are experiencing emotional/behavioural/mental health difficulties secondary to a history of sexual abuse/assault. The team also provides a therapeutic service to children up to age 12 years who are displaying sexually problematic behaviour, and their parents/carers.

Rivers Centre

Tel : 0131 537 6874

E: Rivers.Centre@lpct.scot.nhs.uk

www.rivercentre.org.uk

Support for people experiencing Post-traumatic Stress Disorder.

Royal Edinburgh Hospital

Morningside Place
Edinburgh EH10 5HF

Tel: 0131 537 6000

The Royal Edinburgh Hospital provides two services with dedicated space for sexual abuse survivors:

**Adult Psychotherapy Dept
Young People's Unit.**

FIFE/KIRKCALDY/FALKIRK

Safe Space

4 Victoria Street
Dunfermline, Fife, KY12 0LW
Tel: 01383 739084

E: contact@safe-space.co.uk

www.safe-space.co.uk

Provides a range of support services for those who have experience sexual abuse.

**Kingdom Abuse Survivors
Project (KASP)**

29 Townsend Place
Kirkcaldy KY1 1HB
Tel: 01592 644217
Helpline: 01592 646644
E: info@kasp.org.uk
(for workers)
E: volunteer@kasp.org.uk (for
support)
www.kasp.org.uk

*Counselling and support for
survivors of sexual abuse.
Support for partners and
families.*

**Kingdom Abuse Survivors
Project (KASP)**

2a Burnside North
Cupar, Fife KY15 4DG
Tel/Fax: 01334 656176
E: info@kasp.org.uk
(for workers)
E: volunteer@kasp.org.uk (for
support)
www.kasp.org.uk

*Counselling and support for
survivors of sexual abuse.
Support for partners and
families.*

Open Secret

9 Callendar Road
Falkirk FK1 1XS
Tel: 01324 630100
Fax: 01324 635650
E: info@opensecret.org
www.opensecret.org
*Services for individuals and
families affected by childhood
sexual abuse.*

**Fife Rape & Sexual Abuse
Centre**

29 Townsend Place
Kirkcaldy, Fife KY1 1HB
Tel: 01592 642 336
E: frasc6@hotmail.com
www.frasac.org.uk
*Individual and group counselling
for people who have
experienced sexual abuse.*

Children 1st

Fife Tel: 01383 565 363
www.children1st.org.uk
*Therapeutic services for children
and young people who have
been abused.*

GLASGOW

Breakthrough for Women

4/1, 30 Bell Street

Glasgow G1 1LG

Tel: 0141 552 5483

Fax: 0141 552 7982

Support for women who have been raped or sexually abused.

Routes out of Prostitution

Intervention Team

73 John Street

Glasgow G1 1JF

Tel: 0141 287 5768

Fax: 0141 287 5022

Support for women wanting to leave prostitution.

Thrive

2-6 Sandyford Place

Sauchiehall Street

Glasgow G3 7NB

Tel: 0141 211 8130

E: thrive@glacomen.scot.nhs.uk

Counselling for men who have been sexually abused.

Say Women

3rd Floor, 30 Bell Street

Glasgow G1 1LG

Tel: 0141 552 5803

Fax: 0141 552 9751

E: [say-](mailto:say-women@globalinternet.co.uk)

women@globalinternet.co.uk

Safe, supported accommodation and counselling for young and homeless women who are survivors of childhood sexual abuse and rape/sexual assault.

Glasgow Women's Aid

4/2, 30 Bell Street

Glasgow G1 1LG

Tel: 0141 553 2022

Fax: 0141 553 0592

E:

admin@glasgowwomensaid.org.uk

Support/accommodation for women, children and young people who are or have been affected by domestic abuse.

Greater Easterhouse Women's Aid

0/2, 5 Kildermorie Path

Easterhouse

Glasgow G34 9EJ

Tel: 0141 781 0230/773 3533

Fax: 0141 771 4711

E: collective@gewa.org.uk

Support for women who have experienced domestic abuse.

Rape Crisis Centre

5th Floor, 30 Bell Street
 Glasgow G1 1LG
 Helpline: 0131 552 3200
 Business Line: Tel: 0141 552 3201
 Fax: 0141 552 3204
 E (for workers):
info@rapecrisiscentre-glasgow.co.uk
 E (for support):
support@rapecrisiscentre-glasgow.co.uk
Support for women who have been raped or sexually abused.

Quarriers Family Resource Project

26 Avondale Street, Ruchazie
 Glasgow G33 3QS
 Tel: 0141 774 8202
 Fax: 0141 774 5558
 E: enquiries@quarriers.org.uk
www.quarriers.org.uk
Support for young people and families at risk of exclusion.

Women's Support Project

31 Stockwell Street
 Glasgow G1 4RZ
 Tel: 0141 552 2221
 Fax: 0141 552 1876
 Minicom: 0141 552 9979
 E: wsproject@btconnect.com
www.womenssupportproject.co.uk
Support and information services covering a broad range of issues: support for women whose children have been sexually abused, sexual violence, child sexual abuse and incest, domestic violence and other forms of commercial sexual exploitation.

Children 1st

61 Sussex Street
 Kingpark
 Glasgow G41 1DY
 Tel: 0141 418 5670
www.children1st.org.uk
Therapeutic services for children and young people who have been abused.

HIGHLANDS

Rape and Abuse Line

PO Box 10, Dingwall,
Rosshire IV15 9LH
Tel: 01349 865316 (office only)
Helpline: 0808 800 0123
answered by female support
workers between 7pm and 10pm
Helpline: 0800 800 0122
answered by male support
workers selected evenings
between 7pm and 10pm
www.rapeandabuseline.co.uk
*We provide freephone,
confidential telephone support
for men and women who have
been raped or sexually abused.*

Safe, Strong and Free

PO Box 5610
Inverness IV1 1ZU
Tel/Fax: 01463 712669
E: info@ssf-project.org.uk
www.ssf-project.org.uk
*Information to reduce risk of
child abuse.*

Children 1st

Highland, Tel: 01381 620 757
www.children1st.org.uk
*Therapeutic services for children
and young people who have been
abused.*

NORTH/SOUTH LANARKSHIRE

The EVA Project

Coathill Hospital, Hospital Street
Coatbridge ML5 4DN
Tel: 01236 707767
Fax: 01236 707739
E: lily.greenan@lanarkshire.scot.nhs.uk
*Counselling and support for
women who have experienced
rape, sexual abuse or any other
form of violence.*

The Moira Anderson Foundation

29 Alexander Street
Airdrie ML6 0BA
Tel: 01236 602 885
Fax: 01236 602 877
E: info@moiraanderson.com
*Support, information and training
on sexual abuse.*

Lanarkshire Rape Crisis Centre

Brandon House Business Centre
23-25 Brandon Street
Hamilton ML3 6DA
Tel: 01698 527 006 (admin)
Admin: 01698 527 003 (helpline)
E: info@lrcc.org.uk
www.lanrcc.org.uk
*Emotional and practical support
for women who have been raped
or sexually abused.*

PERTH & KINROSS**Perthshire Womens Aid**

49 York Place
 Perth PH2 8EH
 Tel: 01738 639 043 (helpline)
*Support for women and girls
 who have been raped or
 sexually abused.*

Perth Association for Mental Health

Caladh Centre
 6 Milne Street
 Perth PH1 5QL
 Tel: 01738 631 639
Counselling, support and groups.

Mindspace pk Counselling Service

51 York Place
 Perth PH2 8EH
 Tel: 01738 631639
 E: mind.space@btconnect.com
www.mindspacepk.com
*Counselling and psychotherapy
 providing a service for both
 young and adult people*

OTHER**Survivors UK**

12A Evelyn Court
 Grinstead Road
 London SW9 6WQ
 Tel: 0845 122 1201
 E: info@survivorsuk.org.uk
www.survivorsuk.org.uk
*Telephone support for men who
 have been raped or sexually
 abused.*

Respond

3rd floor, 24-32 Stephenson Way,
 London NW1 2HD
 Tel: 0207 383 0700 (admin)
 Helpline: 0808 808 0700
 E: admin@respond.org.uk
www.respond.org.uk
*Services for victims and
 perpetrators of sexual abuse
 with learning disabilities.*

Bristol Crisis Service for Women

PO Box 654, Bristol BS99 1XH
 Tel: 0117 927 9600
 Helpline: 0117 925 1119
 E: bcs@womens-crisis-service.freeserve.co.uk
*Provides information on
 self-harming for women.*

BASPCAN

10 Priory Street, York YO1 1EZ

Tel: 01904 613605

E: baspcan@baspcan.org.uk

Professional network for workers on preventing child abuse and neglect.

Breathing Space

Tel: 0800 83 85 87

E: info@breathingspacescotland.co.uk

www.breathingspacescotland.co.uk

Free and confidential telephone advice and signposting service for people experiencing low mood and depression.

Victim Support Scotland

15/23 Hardwell Close

Edinburgh EH8 9RX

Tel: 0131 668 4486 (office)

Helpline: 0845 603 9213

E: info@victimssupportsco.demon.co.uk

www.victimssupportsco.demon.co.uk

www.crimeandyoungpeople.net

Support for people who have experienced crime.

SureStart Scotland

Tel: 0870 000 2288 (Public

Enquiry Unit)

www.surestart.gov.uk

Broadbased support for families with very young children. Local contacts are available through the website.

Beyond Trauma is a department of health in mind providing a range of services to people who have been sexually abused.

We aim to assist people who have been sexually abused to reclaim their dignity, rights and sense of self-worth, and to reach a sense of recovery from their abusive past. In order to achieve this we provide a range of flexible services responsive to individual needs. We work in a holistic way, recognising the impact that sexual abuse has in a wide variety of areas (including mental and physical health and wellbeing), as well as the cost of sexual abuse to society.

We also provide information, training and consultancy to staff and volunteers working with people who have been sexually abused.

FURTHER INFORMATION ON CSA AND ON WORKING WITH SURVIVORS:

health in mind's Information Resource Centre has an extensive range of information and resources related to mental health, including a section relating to survivors of childhood sexual abuse. This section includes a large number of books and other resources on issues such as child sexual abuse; self-harm; support for male and female survivors; counselling; and self-help.

To find out more telephone 0131 243 0106 or Email: dawn@health-in-mind.org.uk. Alternatively, visit the Centre at 40 Shandwick Place, Edinburgh (open Mon, Tues, Thurs, Fri 10.00am-12.30pm and 1.15pm-4.00pm)

Other health in mind reports available include:

Beyond Trauma: Mental Health Care Needs of Women Who Survived Childhood Sexual Abuse

Adult Male Survivors of Childhood Sexual Abuse Needs Assessment: Lothian

Beyond Trauma: Mental Health Care Needs of Women Who Survived Childhood Sexual Abuse – Issues For Social Workers And Implications For Their Training

APPENDIX THREE: Concerns About the Safety of Children and Ongoing Concerns About Adults

ChildProtectionLine

24-hour freephone service for reporting child protection concerns, and contacting local social work services.

Tel: 0800 022 3222

www.infoscotland.com/childprotection

Your local police and social work departments will also be able to advise you on the most appropriate contacts for your own area.

Crimestoppers

Can be contacted to anonymously report anyone who has offended against a child.

Tel: 0800 555 111.

There are also a number of phone lines where you can confidentially discuss your concerns, and whether further action may need to be taken:

STOP IT NOW!

Freephone helpline open 9am to 9pm most evenings for anyone worried about their thoughts or behaviours towards children, or the behaviour of others.

Tel: 0808 100 0900

www.stop-it-now.org.uk

Children 1st – ParentLine Scotland

Helpline for anyone caring for children.

Tel: 0808 800 2222

www.children1st.org.uk/parentline/

ChildLine

A free helpline for children and young people in the UK to talk about any problem with counsellors.

Tel: 0800 1111

www.childline.org.uk

18 and Under

This Dundee-based project (see page 53) is also experienced in discussing by telephone the concerns of both adults and young people who are unsure what action to take.

Tel: 01382 206 222

www.18u.org.uk

The Scottish Government has published guidance for Child Protection Committees: a *Framework for Standards* to be used by all agencies with a child protection locus, and the Children's *Charter*, which sets out what every child in Scotland has a right to expect.

Protecting Children and Young People: The Charter

<http://www.scotland.gov.uk/Publications/2004/04/19082/34410>

The Framework for Standards

<http://www.scotland.gov.uk/Publications/2004/03/19102/34603>

Guidance for Child Protection Committees

<http://www.scotland.gov.uk/Publications/2005/02/20675/52303>

Adults who are in need of support and protection:

The Adult Support and Protection (Scotland) Act 2007 (the ASP Act) created new measures to protect adults who are at risk of harm or abuse, and for support services to be provided to prevent ongoing harm. The ASP Act defines who are 'adults at risk' and 'harm'. 'Adults at risk' are adults who:

- (a) are unable to safeguard their own well-being, property, rights or other interests,

- (b) are at risk of harm, and
- (c) because they are affected by disability, mental disorder, illness or physical or mental infirmity, are more vulnerable to being harmed than adults who are not so affected.

The definition of 'harm' is comprehensive and includes conduct which causes psychological harm, such as causing fear, alarm or distress.

Where it is known, or suspected, that an adult is being harmed, local councils have a duty to establish whether further action is required to stop or prevent harm occurring. This permits councils to inquire not only in circumstances where an adult is in their own house or dwelling, but also where they might be in either health or care services. The Act also places a duty on some public bodies, including relevant Health Boards and the Care Commission, to co-operate with a council that is making inquiries about an adult at risk.

Limits of confidentiality:

This will be determined by the organisations where staff and volunteers work. Each organisation and professional body has its own code of ethics and policies, and frontline practitioners are advised to check these for guidance on when you may need to break confidentiality. Your organisation's guidance may also note that it is good practice to inform the young person or vulnerable adult, as far as is possible, about what you need to do and what is going to happen, at each stage.

APPENDIX FOUR: Note on the Authors

SARAH NELSON is a writer and researcher on child sexual abuse and author of *Incest: Fact and Myth*. Topics of her published research papers, book chapters and reports include mental and physical health effects of CSA; sadistic organised abuse; community and schools prevention of CSA; the Orkney child abuse case; national and international campaign issues in CSA. She was Senior Research Officer at *health in mind* until March 2005. From 2006 she has carried out a research study on the needs of men abused in childhood, and has also worked with the Scottish Government on implementation of the National Strategy for Survivors of Childhood Sexual Abuse.

SUE HAMPSON was appointed Training for Trainers (CSA) Co-ordinator at the Scottish Association for Mental Health (SAMH) in 2007. The training programme is 'Safe to Say'. She has worked as a person-centred counsellor, trainer and supervisor for 14 years. She has a background in work with homeless people and refugees, and as a lecturer in further education. She has worked as a counsellor in the NHS, in GP practices and in a mental health team. She has a great deal of experience of working with people who self-harm and who survived CSA. She was Beyond Trauma National Training Officer at *health in mind*, Edinburgh, until 2006.

Who Are These Men?

Who are these men who would do you harm?
Not the mad-eyed who grumble at pavements
Banged up in a cell with childhood ghosts.

Who shout suddenly and frighten you. Not they.
The men who would do you harm have gentle voices
Have practised their smiles in front of mirrors.

Disturbed as children, they are disturbed by them.
Obsessed. They wear kindness like a carapace
Day-dreaming up ways of cajoling you into the car.

Unattended, they are devices impatient
To explode. Ignore the helping hand
It will clench. Beware the lap, it is a trapdoor.

They are the spies in our midst. In the park,
Outside the playground, they watch and wait.
Given half the chance, love, they would take you.

Undo you. Break you into a million pieces.
Perhaps in time, I would learn forgiveness.
Perhaps, in time, I would kill one.

Roger McGough

With grateful thanks to Roger McGough 1993. *Defying Gravity*. London, Penguin

This accessible, easy-to-read booklet aims to help statutory and voluntary sector staff and volunteers likely to be working with survivors of childhood sexual abuse. It will be useful to people in mental health, community projects, counselling and support services, health and social work services, homeless projects, addiction services and older people's projects, and also to those working in young people's services, criminal justice and many others.

We hope it will help you feel more aware and confident in supporting people who disclose sexual abuse, and in feeling able to mention the issue sensitively. It gives important basic information and good practice guidelines for work with male and female survivors. It also includes useful resources and a list of contact organisations.



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This document is also available on the Scottish Government website:
www.scotland.gov.uk

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0131 557 8149

Email orders
business.edinburgh@blackwell.co.uk

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