There is a widely recognised need for better and more joined-up services to help improve support for survivors of childhood sexual abuse. People who have experienced childhood sexual abuse need better access to services and an appropriate response when using services. This booklet aims to support people working in a wide range of services in gaining a better understanding of the needs of people who have experienced childhood sexual abuse, how best to raise the issue, and how to respond in an appropriate, sensitive and supportive way. There is widespread misunderstanding of the needs of survivors of childhood sexual abuse and sometimes a reluctance to raise the issue for fear of opening up a ‘can of worms’. It is important that service providers, practitioners and professionals feel confident, informed and able to support people. This helpful resource aims to make a significant contribution towards achieving better support and services for people who have experienced childhood sexual abuse.

Good support and understanding are more likely to happen if people across Scotland are aware of the reality of childhood sexual abuse and its impact on individuals, families and communities. Evidence shows that people who have experienced childhood sexual abuse are at greater risk of social, physical, emotional and mental health problems in adult life, self-harm and suicide. This significantly increases their need for access to social, healthcare and other services. The booklet reflects our policies on improving mental health and well-being, improving services, improving the quality of life for people who experience mental illness, supporting and promoting recovery and saving lives by helping to prevent suicide. Its cross-cutting nature makes it relevant to health, education, criminal justice, communities, and to the voluntary, statutory and private sectors.
The work of the Cross Party Group in the Scottish Parliament on Survivors of Childhood Sexual Abuse, and the subsequent report of the Short Life Working Group, set up by Scottish Ministers, have led to the creation of a national strategy to help meet the needs of this vulnerable group. A Reference Group which includes adult survivors, and representatives of those involved in supporting them has been set up to take the strategy forward. Part of its remit is to address the need for better training and good practice guidelines and we see this booklet as an important part of this. It is a valuable guide to helping create opportunities for people to disclose sexual abuse which they have experienced, and to raise the question of sexual abuse in an appropriate way. I have no doubt it will prove useful.

Lewis Macdonald
Deputy Minister for Health and Community Care

This booklet has been written for people working with, or likely to be working with, survivors of childhood sexual abuse. 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 our partner organisations, including training for front-line 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, homelessness projects, addiction services, criminal justice, older people’s projects and in young people’s services.

The booklet outlines what sexual abuse is, what its effects can be, and how you might recognise a possible history of childhood sexual abuse in your service users. 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 some contact details for useful organisations.
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 Need of Women who Survived Childhood Sexual Abuse*. Edinburgh Association for Mental Health (obtainable directly from health in mind)

We would like to thank Gregor Henderson, Director of the National Programme for Improving Mental Health and Well-being, for all his assistance to produce this booklet, Julie Dick for her help compiling this resource, Bill Bennett for his helpful comments on early drafts and the many other people within the Scottish Executive who assisted in the development and production of this booklet.

Sarah Nelson
Sue Hampson

*health in mind*, Edinburgh
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.”

Sexual abuse is sexually, physically and emotionally abusive. It breaches the personal boundaries to which all human beings are entitled. Sexual abuse is always a crime.

What Does Child Sexual Abuse Involve?

“What 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.

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1A: 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 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.

Of course, there are often other or additional reasons for these problems. However, the possibility that CSA is part of the underlying reason should always be considered, particularly if someone displays several of the effects listed below. It should also be recognised that many survivors successfully overcome these problems.

There is good research evidence for a link between a history of CSA and particular mental health problems, including post traumatic stress disorder (PTSD), borderline personality disorder, depression, bulimia, suicide/attempted suicide, severe substance misuse, anxiety disorders and loss of self esteem. Sometimes the associations are very strong. For instance, high percentages of people with histories of CSA trauma have consistently been found in those diagnosed with “borderline personality disorder” and “dissociative identity disorder” (previously called multiple personality disorder).

The Impact of Child Sexual Abuse

Many people who experienced sexual abuse as children live successful personal and professional lives in the community, despite their adverse experiences. Being sexually abused does NOT mean people will necessarily suffer the problems 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, discussed below.

“Contact abuse” can include repeated 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, are often 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.

Destruction of self-esteem and sense of worthlessness

Although not the most dramatic effect, it is helpful to introduce this first because it can profoundly influence so many of the problems discussed within the next few pages. 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.
Dissociation exists on a continuum, from being slightly distant, forgetful or emotionally numb, through to blackouts and lost periods of time. As a result, some of these states can be difficult to recognise as dissociation until you are experienced in working with survivors. Dissociation can sometimes be behind apparent mood swings or personality shifts, forgetfulness, dream like states, inattention or “losing time”. It can be frightening and disorienting for the survivor if they can’t remember where they were or what they were doing for some hours, and it could be worth sympathetically exploring the possibility of dissociation and working out ways of “grounding” which work for the survivor, perhaps with help from a mental health professional.

Personality disorders
Many people diagnosed with borderline personality disorder or BPD (usually women) or anti-social personality disorder (usually men), have suffered CSA; often in seriously sadistic ways. Frequently, their abuse has also involved “double bind” relationships with parents and other close carers, who may have behaved inconsistently to the child (e.g. being caring at one time and rejecting at another). Such childhood experiences can lead to serious attachment difficulties, affecting the survivor’s sense of identity as well as the way they relate to others in later life. These difficulties can manifest in the survivor behaving with little emotion and feeling towards others, or veering between dependence and rejection. Self-harm is common, as is dissociation (previously discussed). In situations of extreme, sadistic abuse, children may develop an ability to dissociate from the pain and terror, such that the mind splits into several “personalities”. This is known as Dissociative Identity Disorder (DID) formerly called Multiple Personality Disorder (MPD).

Psychotic episodes
Many survivors experience apparently 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. Although people often receive a diagnosis of serious mental illness (e.g. schizophrenia), it will be important for mental health services to check whether some patients might instead be experiencing severe post-traumatic stress symptoms, as this will affect the treatment and support offered. Care in diagnosis is about listening respectfully to what people who experience mental illness say or write, not simply dismissing it as delusion. For instance, one survivor (now in recovery) had hallucinations of seeing, feeling and smelling her abuser. She recalls fleeing her house, husband and children, and was “sectioned” in psychiatric hospital:

“I started to see beasties everywhere. I felt things were crawling over me. I couldn’t cope here at home, the house didn’t feel safe any longer. I had an urge to get out. The walls I felt were closing in. I saw eyes everywhere: they were just black eyes to begin with, but when I confronted my abuser I realised they were his eyes. I hid in the woods round here”...

Dissociation
When children can’t escape or fight back they will often leave the abusive situation by “taking their minds elsewhere” – e.g. looking down from outside their body, imagining themselves on a cloud, imagining they are someone else. These self-induced trance states are known as dissociation. Sometimes abusers deliberately encourage this, especially through the use of extreme pain. In later life “spacing out” can be much less helpful.

“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.”
A major problem, particularly for survivors themselves, is that personality disorder diagnoses have often become “dustbin diagnoses” for people who behave “badly”, abuse substances, self-harm frequently, or are “hard to treat”. This can result in services, or hospital admission, being denied because of a belief that there are no effective treatments 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 exasperating behaviour. However, the way in which many survivors spin through the “revolving doors” of prison, psychiatric hospital, streets and A&E cannot be cost-effective for themselves, for services, or for society in general.

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.”

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 study revealed that they had tried to kill themselves - sometimes repeatedly. Two had run in front of cars as children and one had tried to throw herself into a quarry. One woman repeatedly ingested bleach, another had suffered life-threatening anorexia and during postnatal depression felt an urge to kill both herself and her child. Often their attempts had either gone unnoticed or were labelled “attention-seeking”. Other survivors had also felt that they didn’t care whether they lived or died. Two had drunk themselves regularly to blackout, while one still swallowed a large daily cocktail of drugs. Nearly all the teenage friends of a drug user who had lived on the streets were now dead. This was just from one research study!

Suicidal behaviour among males 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 assessment had attempted suicide, sometimes several times: “Actually I tried at the ages of 6, 16 and 17, and it wasn’t picked up”...

It is vital that CSA trauma is considered among the possibilities causing children, young people and adults to take, or attempt, their own lives. It is also important that major national campaigns to reduce suicides, such as the Choose Life initiative, integrate issues of childhood sexual abuse trauma into their important work.

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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. It is particularly hard for non-survivors to understand and often makes them feel upset or disgusted. This revulsion can sometimes result in great unkindness to distressed survivors. It is also 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.

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.
Eating disorders
Anorexia, bulimia, or repeated patterns of compulsive eating are often seen in CSA survivors (of course there are also other reasons for these conditions). 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”.

Dysfunctional sexual relationships
Most non-survivors understand how CSA might turn some people off sex altogether, or cause various other problems such as unpleasant intrusive flashbacks during sex, or painful or unenjoyable intercourse, even with loved and trusted partners. However, they can find it harder to understand some survivors turning to apparent promiscuity and sexual risk-taking. Teenagers, in particular, are often stigmatised for this, instead of their behaviour indicating possible abuse and a need for protection. Promiscuity and sexual risk-taking can result from profound disturbance in relationships, from their experience that the only form of affection is sex, from feelings of being utterly devalued and from revulsion against the self.

“I used to go to the 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.”
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.

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. 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. It is important that alcohol and substance misuse services think about the support available for people when they lose this “crutch”.

“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.”

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 disorders, 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, from “body memories”, or from the physical expression of emotional pain. Symptoms of PTSD, 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. Prolonged psychiatric medication can affect health. Many survivors also suffer medically-unexplained conditions, such as irritable bowel syndrome.

“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.”

Anger and aggression:

Though a particular problem for male survivors, women may also find themselves inappropriately taking out their rage on family or colleagues. 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.”
Depression/Postnatal 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. The possibility of a sexual abuse history should be considered in cases of serious, prolonged or repeated postnatal depression:

“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.”

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. 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: “Survivors don’t talk about the can of worms, because for them it’s already open and they’re in the middle of it.”

Chapter 1B: More Subtle Effects of Abuse

Some survivors of sexual abuse present with more subtle signs of abuse. Their symptoms, or behaviour, may be missed, or no link made with CSA (either by themselves or practitioners). Again, it is important to stress that these behaviours may be a result of other contributory factors, and also that many survivors who in the past had struggled with the problems below have gone on to successfully overcome them.

- 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).
- 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.
- In the attempt to have control, they may be rigid in the way they hold their bodies and sometimes also in their home lives: for instance cleaning and tidying their houses repeatedly.
- Men, in particular, may have confusion around their sexual orientation. Some men may overcompensate for this by presenting as very macho. Men are not supposed to be victims in our society, and so can feel unable to show their vulnerability and anger at the abuse. Linked to this, many male survivors have developed homophobic feelings. Others may withdraw completely from sexual activity.
- Many male survivors, in particular, have had chaotic relationships, swinging between a need to be close and a fear of being vulnerable and victimized again. This can lead them to fear intimacy and commitment and can result in a trail of broken relationships, or an inability to maintain long term relationships.

- Many women have also had difficulty with relationships, often ending up in abusive or bullying partnerships where they find themselves re-enacting the original abusive dynamics, being controlled by the partner, and accepting that must be the norm; they do not expect any better for themselves. This is not the same as masochism. Often they also have difficulties with sex; feeling repulsed, confused or dirty, and associating sex with the abuse.
- Many men and women who have been sexually abused find it difficult to create boundaries for themselves which keep them safe. They may find it very difficult to say no, and may be unclear about acceptable behaviour. As a result, they are vulnerable to being “walked over”, disrespected or “put upon” by others. After all, they have all been in situations where their boundaries were physically and mentally transgressed. In extreme situations, this difficulty in creating appropriate boundaries can lead to re-victimisation.
- It is 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, or could not, intervene to stop the abuse. Often survivors who have “blown the whistle” on abusing relatives find themselves isolated in the family. Other abused members of their families can 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.
- Eating problems are common, even where these would not be classified as “eating disorders”. For instance, people’s weight may swing repeatedly from high to low.
- Many women may be overprotective of their children, unable to leave them with babysitters or family members, or to allow them out to play with others. They may be particularly anxious when their child reaches the age they themselves were abused, as this can bring up many unpleasant memories and flashbacks.
So Why…?

This chapter has described ways in which CSA is a risk factor for a range of life problems. So why don’t relevant services, such as those working with drug misuse, homelessness or self-harm, expect to find abuse survivors in their service? Why don’t they build in ways of exploring for the problem, or train and support their staff to work with it? It is, of course, important to address symptoms, and some service users will, in any case, wish to do no more than that. But we might ask why it is that symptoms alone are often addressed, when tackling causes might prove less costly and more effective. Why, too, do adult survivors so often complain that for years on end no-one actually asked them what was wrong?

The next chapter suggests that reasons include: silence among survivors; assumptions and anxieties among workers; and the application of medical models to mental disorders, which make it difficult to accommodate CSA as a cause of some mental health problems.

Don’t Forget the Positives!

It is important to understand the range of possible effects of child sexual abuse discussed in this chapter. It encourages empathy, and helps to identify what might be troubling some service users who have been difficult to help. But it inevitably gives a very negative picture. All staff and volunteers need to remember that survivors of sexual abuse have particular strengths, skills and knowledge to contribute as a result of their experience. 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.

- Some parents find it very hard to display affection to their children, or feel afraid of doing so. This doesn’t mean they do not feel affection, though others might interpret their actions in this way.

- 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 abusers, or abusive networks.

- Survivors are often incredibly perceptive about signals given off by others, and the motivations, intentions and qualities of others.

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CHAPTER TWO: Barriers to “Opening the Can of Worms”

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. Yet without this evidence, services cannot easily access resources or training.

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:

<table>
<thead>
<tr>
<th>Feeling</th>
<th>Description</th>
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<tbody>
<tr>
<td>Shame</td>
<td>They may feel ashamed of what happened to them, or ashamed about people knowing</td>
</tr>
<tr>
<td>Guilt/self-blame</td>
<td>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</td>
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<tr>
<td>Embarrassment</td>
<td>They may feel very uncomfortable about what happened to them</td>
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<tr>
<td>Fear</td>
<td>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</td>
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<tr>
<td>Low self-esteem</td>
<td>They may feel worthless and of no value</td>
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<tr>
<td>Inability to trust</td>
<td>They may have great difficulty trusting because they have been betrayed, often by someone close to them</td>
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<tr>
<td>May not be believed</td>
<td>They may not expect to be believed, or may have experienced disbelief</td>
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<tr>
<td>Helplessness</td>
<td>They may feel they have no power or control over their lives</td>
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<tr>
<td>Numbness</td>
<td>They may have cut off their feelings for short or long periods</td>
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<tr>
<td>Grief</td>
<td>They may feel tremendous loss but may not be clear what this is about</td>
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<tr>
<td>Shock</td>
<td>They may be unable to think clearly</td>
</tr>
<tr>
<td>Don’t care</td>
<td>They may feel “past caring” and might not look after themselves, their body, clothes or environment</td>
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<tr>
<td>Stigma</td>
<td>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</td>
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<tr>
<td>Feeling Dirty</td>
<td>They may themselves feel soiled, or that their bodies are in some way contaminated</td>
</tr>
<tr>
<td>Confusion</td>
<td>They may feel unable to understand their emotions, or to remember clearly</td>
</tr>
<tr>
<td>Sadness</td>
<td>They may feel a great sense of loss and may cry a lot, without making the connection with the sexual abuse</td>
</tr>
<tr>
<td>Anger/disillusionment</td>
<td>They may feel angry with themselves and with others for not helping them, or disillusioned if past attempts to help never succeeded</td>
</tr>
</tbody>
</table>
Barriers for Staff and Volunteers
Claims are often heard that some therapists and social workers are obsessed with sexual abuse, that they “put words into clients’ mouths”, or encourage them to create false memories of CSA. However, it is much more common to find reluctance among statutory and voluntary sector staff and volunteers to broach the issue with clients, or to respond to abuse disclosures. 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
- 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:

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

...Reading this formidable list, we might wonder how the issue is ever addressed at all! Considering the barriers to disclosure and discussion for survivors as well, 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 above, 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.

CHAPTER THREE: The Views of Survivors

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. We have also found that the majority of survivors disagree strongly with professional views about the “can of worms”. Of course, every survivor has his or her own viewpoint: we are talking here about general trends.

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 accurately to 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.”
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 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?’”

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…”

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…then soon after, my occupational therapist I was walking with managed accidentally-on-purpose to take a wrong turn and get lost with me in the street, and we ended up right near the project!”

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 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.

Please don’t assume we’re too vulnerable!

Few things have frustrated, upset and sometimes enraged survivors more than being told they are ‘too vulnerable’ to work on their abuse issues after they have decided to seek help, often after they have spent months on a waiting list! This is a “Catch 22” which deprives survivors of self-determination, control and respect. Of course, some people are more vulnerable than others and will need to go at a different pace or work via different approaches, but if they have taken the decision that they want to address some troubling issues, rejection not only disrespects their own judgment and knowledge: it reinforces their previous experiences of rejection and dismissal.

“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!’”

Was the psychology service below designed to fit real clients, or were clients supposed to fit into someone else’s idea of a service?

“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.”
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:


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!”
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. We, in turn, send out messages about how comfortable we 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.

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.
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

Believe what you are told – you may be the first person who has. 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. Being believed can help the confusion for the survivor, who might doubt themselves and the
nature of the abuse. 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. 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).

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 all right 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 hopelessness of their situation.

**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 and do not assume these are all psychosomatic. 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, this will be mirrored in the work and you will risk failing the survivor. 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.

If you are a manager or senior in such an organisation, it is essential that you make sure adequate supervision and support is in place for workers 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.

CHAPTER FIVE: Wider Issues in Support Planning

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 focused 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, creche 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 routinely be built into the 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
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. 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.

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.
- Talking about sexual abuse, like talking about suicide, does not make things worse – it is an essential step on the road to healing.
- You CAN help survivors by making opportunities for people in distress to disclose sexual abuse where this has happened to them. If someone in distress shows several of the common effects of child sexual abuse, ask them in an appropriate way, whether they have been hurt by someone, or sexually abused, in the past.
- 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.
Thank you for listening! Some useful contacts, addresses and information sources follow.

Contacts, Services, Helplines
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

The contacts in this section 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.

EDINBURGH

Beyond Trauma Team
health in mind
Offers a range of services for survivors of sexual abuse, including: confidential counselling for adult survivors of childhood sexual abuse, emotional and practical support for women, group-work, a young people's project and a national training programme.

40 Shandwick Place, Edinburgh EH2 4RT
Tel: 0131 225 8508
Fax: 0131 220 0028
Email: contactus@health-in-mind.org.uk
www.health-in-mind.org.uk

Gay Men’s Health
10a Union Street
Edinburgh EH1 3LU
Tel: 0131 558 9444
Fax: 0131 558 9060
Email: counselling@gmh.org.uk
Counselling for gay and bisexual men.

Sexual Abuse Survivors Support in Edinburgh (SASSIE)
7b Randolph Crescent
Edinburgh EH3 7TH
Helpline: 0131 220 4722
Support groups for sexually abused women.

Saheliya
10 Union Street
Edinburgh EH1 3LU
Tel: 0131 556 9302
Fax: 0131 556 9302
Email: saheliya@connectfree.co.uk
www.saheliya.org.uk
Counselling and support for Black and Minority Ethnic women.

Edinburgh Women’s Rape and Sexual Abuse Centre
PO Box 120
Brunswick Road
Edinburgh EH7 5XX
Helpline: 0131 556 9437
Email: EWRASAC@aol.com
www.rapecrisisscotland.org.uk
Support for women who have been raped or sexually abused.
Working With Survivors Of Childhood Sexual Abuse

GLASGOW

Breakthrough for Women
4/1, 30 Bell Street
Glasgow G1 1LG
Tel: 0141 552 5803
Fax: 0141 552 9751
Email:
say-women@globalinternet.co.uk
Housing and support for young 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
Email:
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
Email:
say-women@globalinternet.co.uk
Housing and support for young women who have been raped or sexually abused.

Glasgow Women’s Aid
4/2, 30 Bell Street
Glasgow G1 1LG
Tel: 0141 553 2022
Fax: 0141 553 0592
Email:
gwa@ginawade113.fsnet.co.uk
Support for women who have experienced 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
Email: collective@gewa.org.uk
Support for women who have experienced domestic abuse.

Women’s Support Project
31 Stockwell Street
Glasgow G1 4RZ
Tel: 0141 552 2221
Fax: 0141 552 1876
Email:
info@wsproject.demon.co.uk
Support for women who have been raped or sexually abused.

APPENDIX ONE: Contact addresses

Say Women
3rd Floor, 30 Bell Street
Glasgow G1 1LG
Tel: 0141 552 5803
Fax: 0141 552 9751
Email:
say-women@globalinternet.co.uk
Housing and support for young women who have been raped or sexually abused.

Rape Crisis Centre
PO Box 53
Glasgow G1 1WE
Tel: 0141 552 3201
Helpline: 0131 552 3200
Fax: 0141 552 3204
Email (for workers):
info@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
Email: 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
Email:
info@wsproject.demon.co.uk
Support for women who have been raped or sexually abused.
Children 1st
Glasgow
Tel: 0141 418 5670
Therapeutic services for children and young people who have been abused.

FIFE/KIRKCALDY/FALKIRK

Safe Space
4 Victoria Street
Dunfermline, Fife KY12 0LW
Tel: 01383 739 084
Fax: 01383 622 261
Counselling and support for adult survivors of sexual abuse.
Support for partners and families.

Kingdom Abuse Survivors Project (KASP)
29 Townsend Place
Kirkcaldy KY1 1HB
Tel: 01592 644 217
Helpline: 01592 642 336
Email: info@kasp.org.uk (for workers)
Email: volunteer@kasp.org.uk (for support)
Counselling and support for survivors of sexual abuse.
Support for partners and families.

Open Secret
9 Callendar Road
Falkirk FK1 1XS
Tel: 01324 630 100
Fax: 01324 635 650
Email: info@opensecret.org
Web: www.opensecret.org
Support for survivors of sexual abuse and non-abusing parents of children.

Fife Rape & Sexual Abuse Centre
29 Townsend Place
Kirkcaldy
Fife KY1 1HB
Tel: 01592 642 336
Email: frasac6@hotmail.com
Individual and group counselling for people who have experienced sexual abuse.

Children 1st
Fife
Tel: 01383 565 363
Therapeutic services for children and young people who have been abused.

DUNDEE

M-LINE (Male Survivors of Sexual Abuse)
Helpline: 01382 809 111
Support for male survivors of sexual abuse.

Tayside Ritual Abuse Support and Help (TRASH)
Helpline: 01382 207 667
Support for people who have experienced ritual abuse.

Dundee Women’s Aid
61 Reform Street
Dundee DD1 1SP
Tel: Helpline/Office 01382 202 525
Fax: 01382 202 525
Email: dundeewomensaid@freenet.co.uk
Support for women 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 205 556
Email: 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)
Website: www.18u.org.uk
Email: lormac1053@aol.com
Support for young people who have experienced any form of abuse.

PERTH & KINROSS

Perthshire Women’s Aid
49 York Place
Perth
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.
Includes MindSpace, a counselling service for young people.
ABERDEEN

Rape & Abuse Support
1-3 Little Belmont Street
Aberdeen AB10 1JG
Tel: 01224 620 772 (helpline)
Tel: 01224 639 347 (admin)
Email (admin):
info@rasane.wanadoo.co.uk
Email (clients):
rasane@btinternet.com
Support for women and girls who have been raped or sexually abused.

Aberdeen Women’s Aid
66 The Green
Aberdeen AB11 6PE
Helpline: 01224 591 577
Support for women who have experienced domestic violence.

Children 1st
Aberdeen City
Tel: 01224 251 150
Aberdeenshire
Tel: 01346 512 733
Therapeutic services for children and young people who have been abused.

DUMFRIES & GALLOWAY

South West Rape Crisis & Sexual Abuse Centre
93 Irish Street
Dumfries DG1 2PQ
Tel: 01387 253 113
Support for women who have been raped or sexually abused.

Dumfriesshire & Stewartry Women’s Aid
12 Whitesands
Dumfries DG1 2RR
Tel: 01387 263 052
Helpline: 07710 152 772 (24-hour)
Email:
admin@dumfriesswomensaid.org.uk
Support for women who have experienced domestic violence.

NORTH/SOUTH LANARKSHIRE

The EVA Project
Coathill Hospital, Hospital Street
Coatbridge ML5 4DN
Tel: 01236 707 767
Fax: 01236 707 739
Email:
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
Email: info@moiraanderson.com
Support, information and training on sexual abuse.

Lanarkshire Rape Crisis Centre
Tel: 01698 527 006 (admin)
Admin: 01698 527 003 (helpline)
Email: info@lrcc.org.uk
Emotional and practical support for women who have been raped or sexually abused.

BORDERS

Children 1st
Borders
Tel: 01750 228 92
Therapeutic services for children and young people who have been abused.

HIGHLANDS

Rape and Abuse Line
PO Box 10, Dingwall,
Rossshire IV15 9LH
Tel: 01349 865 316 (office)
Helpline: 0808 800 0123
Telephone support for men and women who have been raped or sexually abused.

Safe, Strong and Free Project
PO Box 5610
Inverness IV1 1ZU
Helpline: 01463 712 669
Information to reduce risk of child abuse.

Children 1st
Highland
Tel: 01381 620 757
Therapeutic services for children and young people who have been abused.
Concerns About the Safety of Children

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

Crimestoppers
Can be contacted to report anonymously 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
Website: www.stop-it-now.org.uk

NSPCC Child Protection Helpline
Help and advice if you are worried about a child’s safety.
Tel: 0808 800 5000.
Email: help@nspcc.org.uk.

Children 1st – ParentLine Scotland
Helpline for anyone caring for children
Tel: 0808 800 2222

18 and Under
This Dundee-based project 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

Other

Survivors UK
PO Box 2470
London SW9 6WQ
Tel: 0845 122 1201
Email: info@survivorsuk.org
Website: www.survivorsuk.org
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
Email: admin@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
Email: bcs@womens-crisis-service.freeserve.co.uk
Provide information on self-harming for women.

BASPCAN
10 Priory Street, York YO1 1EZ
Tel: 01904 613 605
Email: baspcan@baspcan.org.uk
Professional network for workers on preventing child abuse and neglect.

Breathing Space
Tel: 0800 83 85 87
Website: 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
Support for people who have experienced crime.

Sure Start Scotland
www.surestart.gov.uk
Broad-based support for families with very young children. Local contacts are available through the website.
CHILDHOOD SEXUAL ABUSE
HEALING & RECOVERY

BEGINNING TO HEAL: A GUIDE FOR FEMALE SURVIVORS OF CHILD SEXUAL ABUSE
Ellen Bass & Laura Davis (Vemilion, £5.99)
An introduction to the healing process for survivors of all ages.

THE COURAGE TO HEAL: A GUIDE FOR WOMEN SURVIVORS OF CHILD SEXUAL ABUSE
Ellen Bass & Laura Davis (Vermilion, £10.99)
A comprehensive guide that offers hope and encouragement to every woman who was ever sexually abused as a child. Based on the experiences of hundreds of survivors and partners, this hugely popular title offers mental and emotional support to those in the process of rebuilding their lives.

also: THE COURAGE TO HEAL WORKBOOK: FOR WOMEN & MEN SURVIVORS OF CHILD SEXUAL ABUSE
Laura Davis (HarperCollins, £17.95)
The companion guide features a combination of checklists, writing/art projects and open-ended questions expertly guides the survivor through the healing process.

I NEVER TOLD ANYONE: WRITINGS BY WOMEN SURVIVORS OF CHILD SEXUAL ABUSE
Ellen Bass (HarperPerennial, £10.99)
Reflecting a wide diversity of experience and emotional response, this moving collection of personal accounts of abuse offers a powerful testament to all survivors.

THE MEMORY BIRD
Caroline Malone, Linda Farthing and Lorraine Maice. (Virago Press, £8.99)
Survivors of Sexual Abuse.

WHO DARES WINS
Laurie Matthew
(Dundee Young Women's Centre)
A straightforward, user-friendly account of issues in ritual abuse.

SECRET SURVIVORS: UNCOVERING INCEST AND ITS AFTERTREATMENTS IN WOMEN
Sue Blume (Ballantine, £10.99)
Blume helps the survivors of hidden incest — those with no memory of abuse whose lives have been made unbearable by its emotional aftermath.

BEYOND SURVIVAL: A WRITING JOURNEY FOR HEALING CHILDHOOD SEXUAL ABUSE
Maureen Brady (Hazelden, £13.95)
A fifty-two week journal of empowerment and self-exploration encourages the survivor to express themselves and gain a meaningful perspective on the past.

DAYBREAK: MEDITATIONS FOR WOMEN SURVIVORS OF SEXUAL ABUSE
Maureen Brady (Hazelden, £8.95)
Affirmations and meditations to be read daily or by subject.

ALLIES IN HEALING: WHEN THE PERSON YOU LOVE WAS SEXUALLY ABUSED AS A CHILD
Laura Davis (HarperCollins, £12.99)
The basic questions are answered and sections include dealing with crisis, intimacy & communication, sex and family issues.

PARTNERS IN RECOVERY: HOW MATES, LOVERS & OTHER PROSURVIVORS CAN LEARN TO SUPPORT & COPE WITH ADULT SURVIVORS OF CHILDHOOD SEXUAL ABUSE
Beverly Engel (Fawcett, £6.99)

OUTGROWING THE PAIN: A BOOK FOR AND ABOUT ADULTS ABUSED AS CHILDREN
Eliana Gil (Dell, £5.99)
Aimed at adult survivors who were abused and neglected.

OUTGROWING THE PAIN TOGETHER: A BOOK FOR SPOUSES AND PARTNERS OF ADULTS ABUSED AS CHILDREN
Eliana Gil (Dell, £7.99)
GHOSTS IN THE BEDROOM: A GUIDE FOR PARTNERS OF INCEST SURVIVORS  
Ken Graber (HCI, £7.99)  
Comfort and guidance for partners in the process of recovery.

SURVIVING CHILD SEXUAL ABUSE: A HANDBOOK FOR HELPING WOMEN CHALLENGE THEIR PAST  
Liz Hall & Siobhan Lloyd (Falmer, £16.95)  
The second edition of this seminal work is aimed at survivors, their partners and professionals.

THE SEXUAL HEALING JOURNEY: A GUIDE FOR SURVIVORS OF SEXUAL ABUSE  
Wendy Maltz (HarperCollins, £11.99)  
Comprehensive guide for men and women.

WHEN THE BOUGH BREAKS: A HELPING GUIDE FOR PARENTS OF SEXUALLY ABUSED CHILDREN  
Aphrodite Matsakis (NH, £9.99)  
How to understand your child’s symptoms and support the healing process.

A MOTHER’S NIGHTMARE: INCEST – A PRACTICAL GUIDE FOR PARENTS & PROFESSIONALS  
John E.B. Myers (Sage, £15.00)  
Assisting parents and professionals in protecting children from child abuse using the legal system, this manual answers critical questions about the experience of abuse and the legal options.

MONDAYS ARE YELLOW, SUNDAYS ARE GREY  
Ellen Prescott (Women’s Press, £8.99)  
Ellen Prescott’s account of her discovery of the sexual abuse of her children and her fight to save them.

STRONG AT THE BROKEN PLACES: OVERCOMING THE TRAUMA OF CHILDHOOD ABUSE  
Linda T. Sanford (Virago, £8.99)  
An authoritative work in which psychotherapist Sanford refutes the notion that those abused in childhood will inevitably become perpetrators in a vicious circle of abuse.

FINGERNAIL MOON: THE TRUE STORY OF A MOTHER’S JOURNEY TO PROTECT HER DAUGHTER  
Janie Webster (Rodder, £6.99)  
Janie Webster left the US in 1990 to escape her husband who had abused their young daughter. This journal recalls their international travels.

CROSSING THE BOUNDARY: BLACK WOMEN SURVIVE INCEST  
Melba Wilson (Seal, £10.95)  
Including testimonials to a wide range of experience.

THE MOTHER I CARRY: A MEMOIR OF HEALING FROM EMOTIONAL ABUSE  
Louise Wisechild (Seal, £10.99)  
Wisechild’s testament to recovery from the pain of childhood emotional abuse by her mother.

BOOKS FOR CHILDREN

NO MORE SECRETS: PROTECTING YOUR CHILD FROM SEXUAL ASSAULT  
Caren Adams & Jennifer Fay (£5.99)  
Providing guidelines to talking with and listening to children. Games and stories to teach prevention.

IT’S MY BODY: A BOOK TO TEACH YOUNG CHILDREN HOW TO RESIST UNCOMFORTABLE TOUCH  
Lory Freeman (£5.95)  
A picture book for parents and professionals to use with children.

LOVING TOUCHES: A BOOK FOR CHILDREN ABOUT POSITIVE, CARING KINDS OF TOUCHING  
Lory Freeman (£4.95)  
A simple, informative picture book to teach children about caring and appropriate forms of touching.

SOMETHING HAPPENED AND I’M SCARED TO TELL: A BOOK FOR YOUNG VICTIMS OF ABUSE  
Patricia Kehoe (£4.99)  
A picture book to help young victims come to terms with their experience.
**THE TROUBLE WITH SECRETS**
Karen Johnsen (£5.95)
A simple book to teach children the difference between good and bad secrets.

**SECRETS: BLACK FAMILIES**
**SECRETS: WHITE FAMILIES**
Khadj Rouf (£4.99 each)
A picture book for children who may have experienced abuse. There are two editions of ‘Secrets’; one depicting a black family and one depicting a white family.

**CHILDHOOD SEXUAL ABUSE: COUNSELLING & THERAPY**

**GOOD PRACTICE IN COUNSELLING PEOPLE WHO HAVE BEEN ABUSED**
ed. Zetta Bear (JKP, £16.95)
Provides the reader with a theoretical understanding of people who have endured abuse situations.

**CHILD ABUSE TRAUMA: THEORY & TREATMENT OF THE LASTING EFFECTS**
John N. Briere (Sage, £13.99)
Briere makes a case for therapy centring around survivors’ strengths rather than focusing on individual psychopathology.

**HEALING THE INCEST WOUND: ADULT SURVIVORS IN THERAPY**
Christine A. Courtois (Norton, £13.95)
Courtois provides a general introduction to incest by category, examines both short and long term after effects, discusses diagnostic process and describes the salient issues and strategies of incest therapy.

**ADULTS ABUSED AS CHILDREN: EXPERIENCES OF COUNSELLING AND PSYCHOTHERAPY**
Peter Dale (Sage, £14.99)
Experiences of both clients and therapists who receive and provide help for the effects of childhood abuse. Presents research into child abuse and psychotherapy and a section tackles the controversy surrounding ‘recovered memory’.

**TREATING SEXUALLY ABUSED CHILDREN AND THEIR NONOFFENDING PARENTS: A COGNITIVE BEHAVIOURAL APPROACH**
Esther Deblinger & Anne Hope Heflin (Sage, £13.99)
Provides an outline for conducting treatment of abuse-related posttraumatic stress reactions.

**GROUP TREATMENT OF ADULT INCEST SURVIVORS**
Mary Ann Donaldson & Susan Cordes-Green (Sage, £17.50)
Includes a discussion of group treatment research issues, preparation for the group therapy process and a description of typical group phases.

**COUNSELLING SURVIVORS OF CHILDHOOD SEXUAL ABUSE**
Claire Burke Draucker (Sage, £12.99)
An accessible, practical guide to counselling both male and female survivors of sexual abuse.

**FEMALE SEXUAL ABUSE OF CHILDREN: THE ULTIMATE TABOO**
Michele Elliott (Wiley, £20.00)
This study includes testimony of survivors and professionals.

**CHILDREN AND YOUNG PEOPLE WHO SEXUALLY ABUSE OTHERS: CHALLENGES AND RESPONSES**
Marcus Erooga & Helen Masson (Routledge, £16.99)
Aimed at professionals in the fields of criminal and youth justice, psychology, health and social care, linking theory to current practice and presenting key research findings on incidence, prevalence and characteristics of young abusers.

**THE MULTI-PROFESSIONAL HANDBOOK OF CHILD SEXUAL ABUSE: INTEGRATED MANAGEMENT, THERAPY & LEGAL INTERVENTION**
Tilman Furniss (Routledge, £22.00)
Accessible advice on specific practical problems and provides an understanding of the multidisciplinary problems and conflicts which arise.

**TREATING ABUSED ADOLESCENTS**
Eliana Gil (Guildford, £13.95)
Practical, step-by-step guidance for mental health professionals illustrated throughout with case studies.
TREATMENT OF ADULT SURVIVORS OF CHILDHOOD ABUSE
Eliana Gil (Launch, £14.95)
Includes topics such as multiple personality disorder, post-traumatic stress disorder, self-mutilation, memory and group work.

MOTHERS SURVIVING CHILD SEXUAL ABUSE
Carol-Ann Hooper (Routledge, 14.99)
A fresh perspective on the problem of women whose children have been sexually abused, drawing on research and theory on other situations involving secrecy and moral dilemmas.

BREACH OF TRUST: SEXUAL EXPLOITATION BY HEALTH CARE PROFESSIONALS AND CLERGY
John Gonsiorek (Sage, £24.00)
Background chapters provide an overview and three key sections deal with victims, perpetrators and responses, including risk management, prevention training and boundary awareness.

WORKING WITH SEXUALLY ABUSIVE ADOLESCENTS
ed. Masud Hoghughi (Sage, £14.99)
An interdisciplinary approach offering a comprehensive overview of working with adolescent sex offenders.

ADULT SURVIVORS OF SEXUAL ABUSE: TREATMENT INNOVATIONS
Mic Hunter (Sage, £12.99)
Three main sections focus on problems of adult survivors, including sexual dysfunction and compulsivity, clients with special needs such as chemical dependency and personality disorders, male survivors and partners of survivors.

CHILD SURVIVORS AND PERPETRATORS OF SEXUAL ABUSE: TREATMENT INNOVATIONS
Mic Hunter (Sage, £12.99)
Includes treating survivors of ritual abuse, treating abuse reactive children and parallel treatment for their parents and societal responses to sexually aggressive children.

CHILDHOOD ABUSE: EFFECTS ON CLINICIANS’ PERSONAL AND PROFESSIONAL LIVES
Helen Jackson & Ronald Nuttall (Sage, £22.00)
The authors identify how gender, age, discipline, individual or belief systems and case factors can affect a person's perception of sexual abuse allegations thus possibly compromising the accuracy of an investigations findings.

TREATMENT STRATEGIES FOR ABUSED CHILDREN: FROM VICTIM TO SURVIVOR
Cheryl Karp & Traci Butler (Sage, £20.00)
A practical workbook for mental health practitioners and advanced students which includes a large format activity manual with reproducible handouts.

CHILD ABUSE, PSYCHOTHERAPY AND THE LAW
Roger Kennedy (FAB, £16.95)
Case studies illustrate therapeutic work with families and helps assist workers to prepare issues that come before the Courts.

FROM VICTIMS TO SURVIVORS: RECLAIMED VOICES OF WOMEN SEXUALLY ABUSED IN CHILDHOOD BY FEMALES
Juliann Mitchell (AD, £13.95)
A research-based resource for professionals which includes an outline of intentions and procedures for verbal and non-verbal treatment methods, including art and writing, which prove effective in practice.

UNSPEAKABLE ACTS: WHY MEN SEXUALLY ABUSE CHILDREN
Douglas Pryor (NYU, £15.95)
Featuring interviews with offenders.
LOST INNOCENTS: A FOLLOW UP STUDY OF FATAL CHILD ABUSE
Peter Reder & Sylvia Duncan (Routledge, £14.99)
The authors review current knowledge about fatal child abuse and discuss an interactional framework for understanding child maltreatment and professionals’ responses to it.

COUNSELLING ADULT SURVIVORS OF CHILD SEXUAL ABUSE
Christiane Sanderson (JKP, £15.95)
An overview of literature on theories of sexual abuse, its impact and long-term psychological consequences and an examination of different models of treatment.

WOMEN WHO SEXUALLY ABUSE CHILDREN: FROM RESEARCH TO CLINICAL PRACTICE
Jacqui Saradjian & Helga Hanks (Wiley, £19.00)
Interviews, construct grids and questionnaires provide a profile of women who abuse - their lives, childhood, own abuse histories and their adult relationships with partners, peers and children - which provides a sound basis for treatment.

Moira Walker (Open University, £16.99)
Walker interviews survivors of physical, sexual and psychological abuse and seeks to understand the context in which abuse takes place.

MALE SURVIVORS
VICTIMS NO LONGER
Mike Lew (Harper Collins 2004)
The classic guide for men recovering from sexual child abuse.

MALES AT RISK: THE OTHER SIDE OF CHILD SEXUAL ABUSE
Frank Bolton et al (Sage, £15.99)
Examines why sexual abuse occurs, how prevalent the problem is among male populations and offers suggestions for clinicians working with sexually abused children. Step-by-step case guidelines are included.

OPENING THE DOOR: A TREATMENT MODEL FOR THERAPY WITH MALE SURVIVORS OF SEXUAL ABUSE
Adrienne Crowder (Brunner £21.00)
Based on current research and the techniques of over forty therapists and their interventions and treatment models.

ADULT MALE SURVIVORS OF CHILDHOOD SEXUAL ABUSE
Kim Etherington (Pitman, £15.95)
Research findings from in-depth interviews with adult men abused in childhood and description of how males respond to their abusive experiences in ways that are rarely understood. Addresses current controversies such as abuse by clergy and ‘false memory syndrome’.

BROKEN BOYS/MENDING MEN: RECOVERY FROM CHILD SEXUAL ABUSE
Stephen Grubman-Black (Ivy, £5.95)
Aimed at male survivors, testimonies describe the experience of childhood abuse and how the memory of abuse haunts the adult life.
MALE SEXUAL ABUSE: A TRILOGY OF INTERVENTION STRATEGIES
John Gonsiorek (Sage, £22.00)
Three different clinical intervention approaches in working with adolescent victims or perpetrators of sexual abuse.

ABUSED BOYS: THE NEGLECTED VICTIMS OF SEXUAL ABUSE
Mic Hunter (Fawcett, £9.95)
Hunter challenges the myths of sexual abuse of male children and examines the physical and emotional impact of abuse on its victims and the factors affecting adult recovery.

BOYS: SEXUAL ABUSE AND TREATMENT
Anders Nyman & Borje Svensson (JKP, £14.95)
The book provides suggestions for treatment and a framework for understanding the issues involved, based on five years’ clinical work in a specialist clinic.

THE MALE SURVIVOR: THE IMPACT OF SEXUAL ABUSE
Matthew Parynik Mendel (Sage, £14.99)
Mendel argues that societal myths and beliefs – such as the invulnerability of male victims – have led to a profound under-recognition of male sexual abuse.

SELF-HARM

LANGUAGE OF INJURY: COMPREHENDING SELF-MUTILATION
Gloria Babiker & Lois Arnold (BPS, £12.99)

BODILY HARM: THE BREAKTHROUGH HEALING PROGRAM FOR SELF-INJURERS
Karen Conterio & Wendy Lader (Hyperion, £12.99)

BODIES UNDER SEIGE: SELF-MUTILATION & BODY MODIFICATION IN CULTURE AND PSYCHIATRY
Armando Favazza (Johns Hopkins, £15.00)

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 & 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: Note on the authors

SARAH NELSON, Senior Research Officer, health in mind is a writer and researcher on child sexual abuse. She is author of Incest: Fact and Myth (1982 & 1987). Topics of her published research papers, book chapters and reports include mental and physical health effects of CSA; challenges of child abuse for social work; sadistic organised abuse; community 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 and is currently a freelance researcher.

SUE HAMPSON, Beyond Trauma National Training Officer, health in mind, has worked as a person centred counsellor, trainer and supervisor for 12 years. She has a background in social work, 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 a mental health team. She has a great deal of experience working with people who self-harm and who survived childhood sexual abuse.
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