visible

Improving health and wellbeing
with adult survivors of child sexual abuse

Childhood Sexual Abuse and Trauma-Informed Practice
– a briefing paper

Our goal is simple: we want to improve health and wellbeing outcomes for adult survivors of child sexual abuse.

Introduction

It is now common to hear about 'trauma-informed care (TIC)', or 'trauma-informed practice'. Many workers, services and institutions are rightly thinking about how to better respond to people who've experienced horrible life events; and who are experiencing ongoing impacts to their physical and mental health. 'Being trauma-informed' basically means understanding what psychological trauma is and what causes it; how to recognise it in individuals and communities; how to respond to it; and how to avoid making things worse for people who are traumatised (1).

Within this, it's important to think about different types of traumatic experience; and about how to respond to people who've suffered specific traumas. It's true that people who've had very different traumatic experiences may experience similar impacts - for example, captured soldiers who've been in prisoner-of-war camps may have many things in common with women who've been in long-term coercive, violent relationships (2). Also, it is likely that people who've experienced abuse will have suffered more than one type – it's been noted that children who experience neglect are five times more likely to also experience sexual abuse, for example (3).

However, there are particular aspects of specific traumas which need to be kept in mind when implementing trauma-informed care. To this end, this paper, written in collaboration between experts by experience; and experts by profession, outlines what to keep in mind when working with people who've experienced childhood sexual abuse (CSA).

Context

CSA is becoming better recognised as a significant public health, mental health and moral issue. It's estimated that 15% of girls and 5% of boys experience some form of CSA before the age of 16 (4). In a city the size of Leeds, this means that approximately 50,000 adults are living with the impacts of CSA.

Despite the sound evidence base around prevalence and impact, the prevailing responses to CSA remain denial, deflection and disbelief (5). Institutions have been slow to recognise the existence of CSA; and have tended towards downplaying its scale and impact. Although this is gradually changing, survivors of CSA still experience a lack of validation, with their experiences often not fully believed, recognised or seen. This can be further compounded by their experiences and 'presentation' being pathologized through inappropriate labelling and diagnosis. The first and perhaps most important factor in CSA work is the value in believing what you are being told – this can be immensely therapeutic in itself.

Types of CSA

CSA can take many forms (6). Most CSA is intrafamilial and perpetrated by an adult known to the victim. Organised abuse takes place when groups of people conspire to abuse one or multiple children (this can include abuse of adults also) – this often also has a basis within the family, though the huge and emerging extent of 'technology-facilitated abuse' means that abusers have ready access to children over the internet, meaning that access via a family member is not required. Child sexual exploitation involves the grooming of young people by organised groups, who take time to befriend and 'help' them before the abuse starts. 'Ritualised' abuse takes this methodology even further; and involves ongoing, repeated torture and psychological manipulation, with the aim of exerting full control (e.g. through the manipulation of dissociative responses to overwhelming fear, pain and stress) over victims who can then be more easily trafficked and abused. This type of abuse is not yet well-understood by many practitioners (childhood sexual exploitation was similarly overlooked and mischaracterised until fairly recently). When implementing TIC, it's important to remember that work in the field of CSA is ongoing; and that thoughtfulness, reflection and research will likely be needed for effective, psychologically safe work.

As mentioned, the majority of CSA is perpetrated by adults, though children and young people can also be perpetrators (adults may be involved with this, though not always). It's also important to note that, although some CSA may be particularly extreme and sadistic, there is no (nor should there be) a hierarchy of which is 'worse'. Focus should be held on how a person has been impacted, rather than what they've experienced.

The specific impacts of CSA

It's vital to listen to people who've experienced CSA, so this section has been written by individuals within Visible who have that background.

There is no cure for trauma, especially the trauma that occurs during childhood. Childhood sexual abuse cannot be cured and yet is often ignored in society. The lack of acknowledgment and support compounds the hurt. The harm caused by childhood sexual abuse is lifelong and profound. The abuse and its aftermath affect the development of systems that are essential for basic human existence - physical, psychological and social. The formation of personality which spans these systems may be affected.

It's important to remember that each person's response to sexual abuse will be different. Seemingly opposite extremes could both be responses to CSA. For example, one person may 'seek attention' while another becomes aloof and withdrawn. Survivors of CSA can be extroverts or introverts. The commonality of these extremes is that neither supports optimal educational and social development. The events of childhood impact a person for life. The development of an individual is altered when trauma occurs. Childhood sexual abuse impacts adult functioning because the development needed was not completed or grew in unusual, possibly negative, ways. The sexual abuse affects social, psychological and physiological (especially brain) development.

Education, mental health and criminal justice systems may perpetuate the trauma by focusing on disruptive behaviours while incorrectly assessing and addressing the situation. Survivors have been labelled 'risky', 'naughty', 'attention-seeking', 'hypochondriac', 'ADHD', 'self-harmer', 'promiscuous', 'personality disordered', etc; meanwhile, the source of these behaviours is seldom sought by caregivers, family and education professionals. Finding the source of such behaviours often requires long-term counselling which is not readily available in either childhood or adulthood. Psychological therapies are expensive or otherwise inaccessible (often because the person is seen as 'too unstable for therapy'). Many professionals and individuals therefore opt for group settings to lessen costs. For survivors of CSA these group encounters can be counterproductive. Group settings can be triggering and can reverse any positive work previously done. Exercises asking members to close eyes, relax, and breathe with strangers were noted to be particularly triggering. Because trust is not easily established with survivors, these social situations can create more stress than intended.

Additionally, confrontational situations within groups can be overwhelming and impede, if not stop, recovery. The financial benefits of group work are likely to be outweighed by the stressors that are inherent to such settings.

Overstretched mental health services may not help survivors of childhood sexual abuse; and may re-traumatise them by mirroring previous circumstances (e.g. by ignoring or not seeing that abuse has taken place; and/or by pathologizing behaviours through unhelpful diagnoses, which can situate 'the problem' within the individual, rather than as something that's arisen from the actions of others). Without long-term counselling, survivors of CSA are constantly questioning their reactions to situations because their development was based in trauma.

When the norms of childhood are shattered a person may deal with the situation by exhibiting extremes of behaviour. For example, a person may feel asexual; or alternatively engage in hypersexual behaviour, when struggling with CSA issues. Survivors of CSA may have to learn or relearn developmental milestones. Such intense psychological development takes money, time, effort and trust, but our current systems are not structured to deal with this reality. Therapy through the NHS is short-term and focuses on quickly changing behaviour and thinking. These types of changes cannot happen quickly for survivors of CSA, because these patterns were established during childhood development. Without a long-term intervention, survivors are left second guessing every aspect of life. Since 'normalcy' was never established, survivors of CSA may neither successfully understand nor participate in commonplace activities such as marriage, child rearing and staying physically healthy. Of course, CSA effects each person differently – though the after-effects of CSA are always pervasive and profound. This is why services that focus on short-term goals and quick fixes do not work. Indeed, the current NHS and other psychological services may further isolate persons trying to heal from CSA by offering therapies such as mindfulness and behavioural groups that accentuate differences between survivors of CSA and others seeking help. The lack of understanding by group members can trigger distress as described above.

A survivor's inability to engage with services offered is not a failure, but rather a sign that different approaches are needed. Without the right support survivors may lurch from crisis to crisis at the expense of much time and money. The right support in the long term saves resources by averting crises and unnecessary, ineffective therapies. Throughout the lifespan, physical and psychological systems should work together. CSA can suppress or break the interaction of these systems.

Physical responses to abuse often remain hidden because each physical problem is treated individually. The psychological and developmental origins of bodily disorders are little understood and therefore often get ignored by doctors and health professionals. Even if a doctor suspects psychological factors in a physical illness, healthcare services are not currently structured to offer a holistic approach. For some survivors of CSA, even attending a medical appointment alone may cause such anxiety and distress that the appointment is missed. Moreover, friends and family members may tire of offering support for such seemingly commonplace activities.

The healthcare system may interact with the family system to further disadvantage a survivor of CSA. In order to stop the additional fallout, persons who have been sexually abused need to be recognised and offered the right support to address their needs. The following table summarises some of the issues that survivors may experience:

SOCIAL	PSYCHOLOGICAL	PHYSIOLOGICAL
Self-imposed isolation	Fear/anxiety	Changes in brain development
Hyper-vigilance (self and others)	Low Self esteem	Hormone changes
Fight, flight, freeze, flop responses to social situations	Attachment issues	Neurological problems/ damage
Avoidance/compliance	Empathy/apathy/ distain	Digestive problems/nausea
Not wishing to be touched	Blame, shame, guilt	Chronic fatigue (various forms)
Hyper-sexualised/non-sexualised	Dissociation	Autoimmune disorders (Various Forms)
'Attention-seeking' (or more accurately, attention-needing/'acting-out'/aloofness	Suicidality	Chronic pain (various forms)
Mitigation of perpetrator	Suppression	Memory lapses/loss
Easily overwhelmed (even with minor problems)	Minimising negative emotions	Reproductive system problems
Intense distress when events and persons remind of abuse	'Personality disorders'/'psychosis'	Multi-system problems/ Complex 'disorders'
Inability to have stable family and social relationships	Substance abuse issues	Nightmares, sweating, palpitations
Inability to trust others (or themselves); or tendency to trust unreliable persons	PTSD/flashbacks/ intrusive thoughts	Problems with sensory systems
Worldview inconsistent with social norm	Difficulty making decisions	Bladder and bowel issues stemming from abuse.
	Eating 'disorders'	Hypermobility Syndrome


I wish that someone had asked me sooner what had happened to me

Additional issues to consider

For a good overall grounding in the effects and impacts of CSA, reporting from the Independent Inquiry into Childhood Sexual Abuse offers seven general aspects:

Physical health

Emotional wellbeing, mental health and internalising behaviours

Externalising behaviours

Interpersonal relationships

Socioeconomic

Religious and spiritual belief

Vulnerability to revictimization (7)

Further issues that need to be kept in mind are:

- Childhood Sexual Abuse Material – child abuse images and films circulating on the internet now number in the millions (8). People who've had their abuse filmed have to live with this reality – knowing that people are still seeing and taking gratification from their suffering. This is another factor that can mark CSA out from other types of trauma.
- CSA takes place very secretively, which can result in increased shame and stigma for the person who's experienced it. Perpetrators of CSA often manipulate victims into thinking that the abuse was 'their fault'; or that they are somehow defective and 'wrong'. Inadequate implementation of TIC can compound these factors, as workers/services without the requisite skills and knowledge can inadvertently 'shame and blame' victims.
- Perpetrators are, to some extent, still felt to be 'strange/weird', when in fact they are generally well-respected and liked people; very 'ordinary' seeming; and sometimes with high-status positions in society.

- Linked to the above, perpetrator denials of guilt may well have been believed within families and institutions, further compounding issues around self-blame and guilt for survivors. The lack of justice, with the vast majority of CSA cases not being reported, let alone proceeding to successful convictions, is another issue that survivors have to contend with.
- Perpetrators of abuse may still be present in survivors' lives – particularly if they are family members. Although some people manage to distance themselves from abusers as adults, this may not be possible for all, as they may need support from families; or wish to maintain contact with non-abusive family members. Even if the abuse has stopped, contact with perpetrators will obviously be hugely impactful. And sometimes the abuse does persist into adulthood. The secrecy associated with this means that it may not be seen by practitioners.
- Because abusers may be family members who offer care and support alongside the abuse, survivors may experience 'complex trauma' – this is when attachment patterns are disrupted, leading to survivors yearning for contact with others; whilst simultaneously being terrified of contact with others. This kind of attachment 'style' can be easily overlooked and stigmatised within services, leading to re-traumatization, e.g. by a person being seen as 'non-engaging' and then discharged - leading to resonances with previous abandonment and rejection experiences.
- Victims may have been forced to participate in the abuse of other children – this will of course compound shame and guilt responses.
- Trust in professionals may have been deliberately undermined by perpetrators, resulting in huge challenges in seeking support or justice at the time of the abuse or later in life (and authority figures may actually have been involved in the abuse).
- Complex dissociation issues associated with particularly sadistic (often organised) abuse, linked to the diagnosis of Dissociative Identity Disorder, are not well-understood within most mental health services; and can often be overlooked or even disbelieved.
- Specific anniversaries or dates may be really hard for survivors, particularly for those who've experienced ritualised abuse; and can trigger self-injury or suicide attempts.

Trauma-Informed Practice with survivors of CSA

Probably the most important aspect of TIC is an understanding of the value of psychologically safe 'relationship'; and this is of paramount importance to people who've experienced CSA. Survivors will almost certainly lack trust in others, so the opportunity to build trust and have an experience of other people as being 'safe' is invaluable. This will probably take a significant amount of time, however, so service 'offers' should look past the short-term wherever possible. Moreover, it is helpful for the general public to understand this, so that it becomes 'everyone's business' to support psychological healing in CSA survivors.

As mentioned earlier, being believed is one of the most helpful things a survivor can experience. True, authentic compassion when hearing a disclosure of abuse; and non-judgemental attitudes towards how a person is 'presenting' in general, are crucially important. An understanding of the wide range of trauma manifestations, e.g. anger, over-compliance, dissociation, emotional distress, avoidance, self-injury, suicide attempts (this is far from an exhaustive list) is necessary, as is the value of looking beyond these at a surface level and seeing the possibility that past abuse is at the root of them.

All survivors of CSA need to be heard and really listened to, but some who are particularly distressed/dissociative may need a more active 'grounding' response – workers should familiarise themselves with grounding techniques that can support a person to stay in the 'here-and-now' (9)

TIC involves practitioners and workplaces being reflective and self-aware, otherwise harm may inadvertently be caused to survivors – and to workers themselves, through issues such as burnout, compassion fatigue and vicarious traumatization (10). Support must be offered to workers who are engaged in CSA work.

For more information

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References

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(4) Centre for Expertise on Child Sexual Abuse, https://www.csacentre.org.uk/our-research/the-scale-and-nature-of-csa/infographics/

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(8) Figures from Interpol, https://www.interpol.int/en/Crimes/Crimes-against-children/International-Child-Sexual-Exploitation-database

(9) https://www.mind.org.uk/information-support/types-of-mental-health-problems/dissociation-and-dissociative-disorders/self-care/

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At Visible, we are a catalyst for health and social care services system change across Leeds and beyond. We encourage, shape and instigate this change, using the experience of survivors to influence every aspect of the way we work.