The Report of the Scottish Executive Short-Life Working Group on the care needs of people who have survived childhood sexual abuse

Services for Adult Survivors of Childhood Sexual Abuse

Contents

Services for Adult Survivors of Childhood Sexual Abuse

Executive Summary

1. This report highlights the enormity of the challenge in meeting the needs of survivors more effectively. But, as has been pointed out by the Cross Party Working Group (CPG), this is not a *new* population. Survivors are already receiving services from health and social care agencies in particular but, in most cases they are not receiving an integrated and coordinated service that responds to the complex needs of the whole person.

2. Childhood sexual abuse (CSA) is increasingly recognised as a major cause of morbidity and mortality. Two recent World Health Organisation (WHO) reports – **World Report on Violence and Health** (2002) and **World Health Report 2002** (2002) – acknowledge that CSA is common in both females (20%) and males (5-10%). CSA is even more prevalent in specific populations including substance abusers, the homeless and psychiatric inpatients.

3. CSA is underreported with 10-17% reporting the abuse to child protection services and less than 1% of cases documented in health records. The consequences of CSA include mental health problems (including suicide and eating disorders), physical illness, and behavioural and social problems. The increased cost to hospital services of managing the health consequences of CSA for women in Scotland is estimated to be £30-60 million per annum.

4. There is no clear responsibility for identifying or supporting adult survivors of CSA within primary health or mental health services at present.

5. The voluntary sector has considerable expertise in helping adult survivors of CSA and currently provides the only substantial data collection. With adequate support and funding the voluntary sector could provide a vital function for the statutory sector. Currently this remains far from the case.

6. A significant problem for survivors of sexual abuse is that CSA is not widely recognised as a major contributing factor to a range of seriously disabling behaviours such as self-harm and substance abuse. It is therefore unsurprising that the emphasis in practice is largely placed upon treating the symptoms and minimising harm rather than supporting service users to explore aspects of their sexual abuse history which are problematic for them, and develop strategies for coping positively with daily life.

7. Survivors report that the people who help them do not come from any one professional background or use a particular therapeutic approach. They do not necessarily have high professional status. The majority have not attended specific training courses on child sexual abuse, although they had gathered expertise in other ways. Rather, they were secure and firm about boundaries, but related with warmth and kindness. They were informed and aware about the main effects of CSA trauma and had examined their own personal issues around working with sexual abuse. They worked non-hierarchically, consulting respectfully with survivors about what their main needs were and what their service could offer. They neither hid behind confidentiality nor broke it insensitively.

8. Given the complexity and diversity of issues arising from CSA it is essential that a range of services is developed. Survivors and professional workers have identified services models that are beneficial. These include a 24-hour telephone helpline, a crisis house, counselling, groupwork (both self-help and facilitated therapeutic work), respite and services that are able to work with and stick with people who present with challenging behaviours.

9. There is a need for more public awareness of the issues around childhood sexual abuse and how to protect children from perpetrators. There is also a need for people to know where to get help as survivors or as potential perpetrators.

10. Staff also need awareness raising about the common effects of CSA trauma, the relevance of CSA to their particular client group and their feelings about working with CSA. This training would be especially useful for anyone who works in an environment where there are likely to be many clients with a history of CSA. This includes psychiatric units, prisons, special hospitals, primary care, children's home/secure units, accident and emergency departments, self-harm projects, drug and alcohol projects, reproductive health, eating disorder projects, counselling projects, schools for emotional/behavioural problems, homelessness work.

11. For the vast majority of adult survivors, a more humane, open and empathetic service response is all that is required. This sounds simple and could be if the quality of services was assessed on these criteria.

12. From a policy perspective, it is essential that adult survivors work is integrated into existing areas of activity, rather than spawning a whole new infrastructure and sub-specialisation. There are also important links to be made with mental health policy.

13. The impact of childhood sexual abuse on a variety of health conditions is poorly understood, but given its prevalence, more thought is needed on its impact in clinical practice. For example, thought is needed on the possible impact this has on certain investigative procedures.

14. There is national and local work that is required to meet the needs of survivors more effectively. Obtaining better baseline data from both specialist and also mainstream services is a priority.

Recommendations

1. The Scottish Executive should incorporate the issue of adult survivors of childhood sexual abuse into policy developments around child protection, domestic abuse and mental health services. This policy work should cover prevention, treatment, support and recovery from the effects of childhood sexual abuse.

2. There needs to be a broad-based awareness campaign that challenges current public and professional attitudes. The campaign should make the links between childhood abuse and adult mental health problems. It is suggested that adult survivors are involved in the development of the campaign and that links are made to See Me the national campaign tackling stigma and discrimination. There is also a role for NHS Health Scotland in counter-acting the secrecy associated with sexual abuse.

3. There needs to be a training strategy that puts childhood abuse on the curricula for basic training in nursing, medicine, social work and criminal justice (including police). For post-graduate training, we recommend the issues for adult survivors are integrated with training for child protection, domestic abuse and patient communication.

4. NHS Quality Improvement Scotland needs to develop national standards for the care of adult survivors of childhood sexual abuse who are cared for in mental health services. These standards would incorporate the need for a gender-sensitive approach to providing services. Survivors themselves should be involved in developing these.

5. A needs assessment should be undertaken of the prison population with particular attention to those on remand and with short sentences.

6. Medical and nursing bodies should review relevant areas of clinical practice and develop guidelines for undertaking sensitive examinations in adult survivors of sexual abuse. Involving survivors themselves in this work would be critical to its success.

7. NHS Health Scotland should encourage self-help tools, for instance through the marketing of Breathing Space, the national helpline as a source of help for adult survivors. The Justice and Education Departments of the Scottish Executive should develop materials for use in schools, communities and the web. Uptake should be evaluated to assess its impact.

8. Local commissioners need to urgently develop services to support adult survivors in line with best practice. This means supporting non-statutory services where they exist, ensuring they are put on a more secure financial footing, and evaluating good practice models. It also means dedicating resources towards and improving the quality of care in existing mainstream services in recognition of the strong association between CSA and significant mental health problems, reflecting the needs of survivors. More specialist services to provide support and treatment for survivors at the severe end of the spectrum are needed. There is also a need to join up approaches around services for children affected by sexual abuse and adult services in this area. Progress on implementing local service change should be monitored through the NHS Performance Assessment and Accountability Framework, and the Community Planning/Health Improvement process.

9. Better data collection about survivors is needed in addiction services, primary care, mental health, GUM, obstetrics and gynaecology, and Accident and Emergency. This will help to improve our understanding of the extent of the health needs of survivors.

10. It is recommended that there should be support for a network of researchers, practitioners and survivors with an interest in improving the care and treatment of adult survivors.

Services for Adult Survivors of Childhood Sexual Abuse

1. Introduction

1.1. This report originates from the work of the Scottish Parliament's Cross Party Group (CPG) on Survivors of Childhood Sexual Abuse, and from Sarah Nelson's **Beyond Trauma: Mental Health Care Needs of Women Survivors of Childhood Sexual Abuse** research report which highlighted service failings. Since its launch in 2001, the CPG group has held parliamentary debates, undertaken research and encouraged a broad cross-governmental approach to the issue. In response to their concerns, the Minister for Health and Community Care, Malcolm Chisholm set up a Short-Life Working Group on the Care Needs of People who are Survivors of Childhood Sexual Abuse (CSA). This report is the result of the work of the Short-Life Working Group to date. Its remit and membership is set out in Appendix 1.

1.2. The group commissioned a literature review and took evidence from a range of professionals and services. It met with the Scottish Parliament's CPG and wherever possible has taken on board many of that Group's concerns. This report takes into account all of this information and the discussions that flowed from them. It marks a stage in a bigger process of bringing attention to this complex issue and finding effective ways of dealing with it.

1.3. The group took this report to a wider range of people working in many different agencies and areas of Scotland and has changed the report to reflect this input. Two survivors talked about their experiences of service responses at this meeting. Their testimonies are attached in an appendix along with a list of participants at the wider event.

1.4. It was accepted by the group that whilst the scientific evidence-base for effective interventions was relatively limited, this was no reason for inaction. The group took the view that other forms of knowledge were also important, not least the view of survivors themselves.

1.5. This report is structured into 7 main chapters. Chapter 2 sets out the purpose. Chapter 3 covers the broad policy context and background. Chapter 4 summarises an extensive review of the literature in terms of the prevalence of CSA and the health and social consequences of CSA. Chapter 5 looks at models of care currently being advocated for mental health services and examines their effectiveness for this client group. The chapter goes on to explore the need for models in other services and agencies. Chapter 6 covers the wide range of training issues related to this client group. Chapter 7 draws some conclusions and makes some recommendations on taking this work further.

2. Purpose of Report

2.1. This report highlights the enormity of the challenge in meeting the needs of survivors more effectively. But, as has been pointed out by the Cross Party Working Group, this is not a new population. Survivors are already receiving services from health and social care agencies in particular but, in most cases they are not receiving an integrated and coordinated service that responds to the complex needs of the whole person.

2.2. However, this issue is of crucial/urgent importance. In the words of James Mercy from the Center for Disease Control in Atlanta, Georgia,

> 'Imagine a childhood disease that affects one in five girls and one in seven boys before they reach 18; a disease that can cause dramatic mood swings, erratic behaviour, and even severe conduct disorders among those exposed; a disease that breeds distrust of adults and undermines the possibility of experiencing normal sexual relationships; a disease that can have profound implications for an individuals future health by increasing the risk of problems such a substance abuse, sexually transmitted diseases, and suicidal behaviour; a disease that replicates itself by causing some of its victims to expose future generations to its debilitating effects.
>
> Imagine what we would do as a society if such a disease existed. We would spare no expense. We would invest heavily in basic and applied research. We would devise systems to identify those affected and provide services to treat them. We would develop and broadly implement prevention campaign's to protect our children.
>
> Wouldn't we?'

2.3. One of the main findings from our discussions was the level of stigma associated with this problem. Society's uneasiness and reluctance to engage with this topic is a reflection of the secrecy that occurs within the family of origin similar to domestic abuse or other trauma occurring within the 'sanctity' of home. It is difficult to talk about this issue because:

- As a society, we are far from comfortable in talking about sex.
- Under-age sex is deemed particularly problematic to talk about.
- Where there is sexual abuse, there is often secrecy, denial and collusion, which again makes it difficult to talk about in an open way.
- There can also be threats of violence if any disclosures are made and these threats can remain powerful even when the child becomes an adult.
- Staff working with survivors are fearful of being perceived as abusive or re-traumatising when asking questions. Partly this is related to a need for the staff to gain confidence in working with this material. It is also an expression of the dynamics that are recognised in working with this group. The survivor, basing their expectation of contact on their early traumatic relationships can unconsciously re-enact these causing the interviewer to variously feel abusive or caring, idealised or denigrated with the survivor occupying the opposite role. Understanding this is central to working in a helpful therapeutic way.

2.4. However, so long as adults decline to provide the space for such matters to be discussed openly in a safe manner, children remain vulnerable to abuse and survivors struggle to articulate their experiences in ways that promote their recovery and healing.

2.5. The scale of the challenge is clear. We suggest a response that both strengthens existing good work in this area and enhances the capacity of the whole system of public services (statutory and voluntary) to rise to this challenge in partnership. There are already a number of national initiatives which can be built on with survivors needs in mind. We also need to ensure local strategy makes these links and provides a firm basis for local work.

3. Policy Context

3.1. Childhood sexual abuse is increasingly recognised as a major cause of morbidity and mortality. Two recent World Health Organisation (WHO) reports – **World Report on Violence and Health** (2002) and **World Health Report 2002** (2002) – acknowledge that CSA is common in both females (20%) and males (5-10%). This chapter deals largely with health and social policy, whilst recognising there are other areas of work, for example in criminal justice policy that are relevant.

3.2. The main effects of childhood sexual abuse in adulthood are psychological, although the behavioural, social and physical consequences are no less important. As a result, mental health policy has the biggest impact on the development of appropriate services. Yet until recently, the major policy documents in this area have paid little attention specifically to the needs of adult survivors as is illustrated below.

3.3. Mental health policy in Scotland is set out in a number of key documents. **The Framework for Mental Health Services in Scotland** (1997) sets out the structures and design of services predominantly for people with severe and enduring illness. **Working Together for a Healthier Scotland** (1999) raises the importance of mental health promotion as a key component to public health strategy. **Our National Health** (2000) provides further impetus in this area with the development of a national programme for mental health and wellbeing. It also adds in the need for better services in primary care for people with mild to moderate mental health problems. More recently, the **Mental Health (Care and Treatment) (Scotland) Act** (2003) has been passed, emphasising the need for improved care and treatment services locally. However, despite evidence that points to significant mental health problems experienced by survivors, these documents rarely mention survivors' needs.

3.4. **Mind the Gaps – Meeting the Needs of People with Co-occurring Substance Misuse and Mental Health Problems** (2003) makes a valuable contribution to current thinking on how best to respond to complex care needs, particularly so as survivors often appear in such services. It recommends the 'earlier detection of abusive experiences, by facilitating disclosure and acceptable intervention', the need for 'staff trained to develop skills and confidence necessary to identify and understand clients with co-occurring problems'.

3.5. There is wide recognition for the impact of sexual abuse in children's policy in Scotland. Recent work in the area of child protection began before devolution with **Protecting Children – A Shared Responsibility** (1998). **For Scotland's Children** (2001) calls for more integrated working across all services. **It's Everyone's Job to Make Sure I'm Alright** (2002) puts a focus specifically on agencies involved in child protection, and growing concerns about internet abuse and child prostitution emphasise the need for continued vigilance. Links have been made between child protection and domestic abuse, but until now, there has been little recognition of the links between child protection and adult survivors of childhood sexual abuse. For example, links are not currently made in child protection documents between the needs and welfare of adult survivors, and the needs of abused children, nor between domestic violence and CSA; nor are the strengths and knowledge which survivors may have to offer acknowledged.

3.6 Recognising the links between the needs of child and adult survivors is important, both to help spread awareness and knowledge, and to provide recognition that for some survivors abusive experiences can be a life-long burden. For example, the experiences of survivors of sexual abuse in institutional care settings can be so painful and unhappy that their ability to trust

others has been shattered, and their feelings of anger, guilt and self-worth can inhibit how they build and maintain relationships. Despite this, survivors often have great resilience, and it is not uncommon for partners, relations and family networks to be unaware of past abuse and, even for those that do know, can result in relationships which are strained, placing significant pressures on family members to remain supportive. These are sensitivities that need to be taken into account when working with survivors, and their families, and in how services should be configured to best meet needs in the short, and longer, term.

3.6. The **Scottish Needs Assessment Programme (SNAP) Report on Child and Adolescent Mental Health** (2003) points out the connections between family circumstances (including abuse) and mental health problems. In many instances, mothers disclose their own experience of abuse after it has happened to their child. Clearly there are links to be made between this work on child and adolescent mental health and the service response for adult survivors.

3.7. Despite the evidence in the literature, there is even less recognition of the effects of childhood sexual abuse on adults in other services. These include substance misuse, criminal justice, gynaecology, maternity and primary care services.

3.8. The Department of Health Strategy for Women's Mental Health Services points out that this under-recognition and lack of understanding of behavioural and physical consequences of sexual abuse in childhood can lead to a re-traumatisation of survivors by the services ostensibly there to help.

3.9. **The National Programme for Improving Mental Health and Wellbeing** (2003) offers some signs of the shift in thinking that is required to help adult survivors. One key aim of this programme is to reduce stigma and discrimination among people with mental health problems. Adult survivors and service providers have many concerns around the stigma and discrimination they experience, which again puts survivors at risk of re-traumatisation. A further key aim is to reduce suicide and self-harm with more details of this set out in **Choose Life: A National Strategy for Suicide Reduction in Scotland** (2002). Adult survivors are at higher risk of self-harm and people diagnosed with personality disorder (many of whom are adult survivors of CSA) account for about 15% of all suicides. Another key aim of the programme is to encourage a culture of hope and recovery. This is essential for survivors of childhood sexual abuse and is exemplified by the few specialist non-statutory services who work with this client group.

4. Review of the Literature in Terms of the Prevalence of CSA and the Health and Social Consequences of CSA

4.1. Definition

4.1.1. Definitions of CSA vary between studies, which makes comparison between studies difficult. For the purpose of this work the following definition has been used: 'Any child may be deemed to have been sexually abused when any person(s), by design or neglect, exploits the child, directly or indirectly, in any activity intended to lead to the sexual arousal or other forms of gratification of that person or any other person(s) including organised networks. This definition holds whether or not there has been genital contact and whether or not the child is said to have initiated, or consented to, the behaviour'[1]. While this is a broad definition of CSA, there is evidence that adverse outcomes can result from all types of CSA.

4.2. Prevalence in the general population

4.2.1. Childhood sexual abuse is common. Historically, however, the prevalence of CSA in the UK has been underestimated at 12% for females and 8%[2] for males. Comparing the estimate for females with international studies shows that this estimate is at the lower end of the range (7-36%). The World Health Organisation (WHO) puts the prevalence of CSA at 20-25% for women[3]. Using the equivalent WHO estimate and findings from the international literature, a prevalence of 5-10% is the best estimate for men.

4.3. Prevalence in other populations

4.3.1. Some populations are at higher risk of CSA, and the adverse effects of CSA, than the general population. Studies of these populations have followed a number of different study designs, and are of varying quality. The effect of study design is best illustrated by looking at the estimates from uncontrolled studies of substance abuse services and gynaecology clinics which reported the prevalence of CSA in women as 90%. These estimates from uncontrolled studies have therefore not been quoted in Table 1. The range of prevalence for these populations is useful for planning services.

Population	Prevalence by gender
Psychiatric inpatients[4]:	13-70% (F)
Homeless[5]:	38-50% (F); 32% (M)
Substance abuse[6-10]:	37-51% (F); 24% (M)
GUM clinics[11]:	37% (gay and bisexual M)
General practice[12]:	20% (F)
Students (non-contact CSA)[13]:	54-59% (F); 27% (M)
Students (contact CSA)[13]:	21% (F); 7% (M)

Table 1.

4.4. Severity

4.4.1. More severe outcomes can be predicted if the CSA is frequent and prolonged, involves penetration and/or is perpetrated by somebody who is known by the abused – such as a family member. Nonetheless, adverse outcomes can also occur following less severe abuse[14]. The prevalence of more severe abuse is more difficult to estimate with certainty. However one well designed Australian study of the general female population provides a useful breakdown into

severity of abuse[15]: 32% described some form of CSA, 25% reported CSA involving physical contact, 20% reported abuse involving contact with the victim's or perpetrator's genitals, and 6% involved actual penetration. A UK survey of young people (16-24 year olds) conducted by the NSPCC found a prevalence of non-contact CSA of 21% for females and 11% for males, and a prevalence of contact CSA of 16% for females and 7% for males[16].

4.5. Routine data

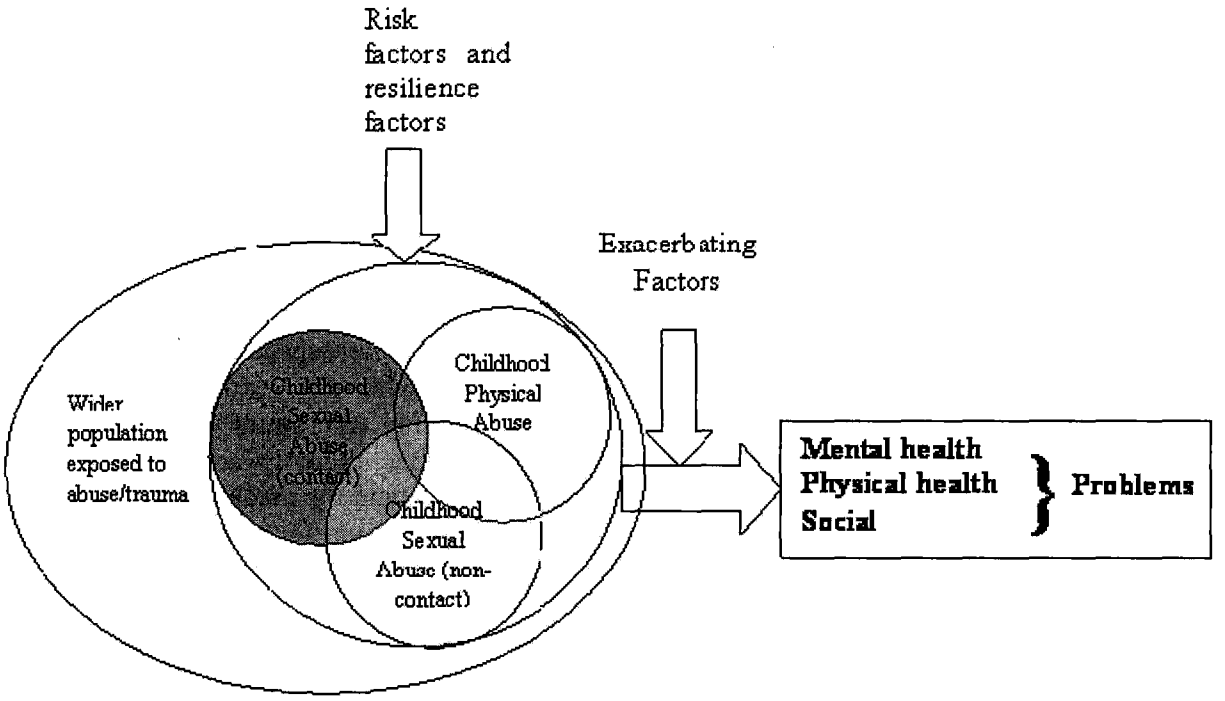
4.5.1. Health service data does not provide an accurate estimate of prevalence of childhood sexual abuse (CSA) either overall or within high risk populations. Between 1999-2002, for the whole of Scotland, only 13 hospital discharge records coded for child abuse, none of which was for CSA (Scottish Morbidity Records – Information and Statistics Division). In Scotland for 2000-01 the prevalence of sexual abuse using GP spotter data was 0.01% for males and females under the age of 18 (Continuous Morbidity Recording – Information and Statistics Division). Only 10-17% survivors report CSA to child protection services [17-19]. Clearly these figures reflect inaccuracies in reporting. *Open Secret* a voluntary organisation covering Clackmannanshire, Falkirk and Stirling recorded 254 referrals (42 males and 212 females) to their service in 2003. 217 of these referrals were survivors seeking support specifically relating to consequences of childhood abuse.

4.5.2. In Dundee, a sectorised psychodynamic psychotherapy service accepted referrals outside catchment for adults with a history of childhood sexual abuse and recorded 578 referrals over a 6 year period between 1996 and 2002. 183 men were referred, 84 of these men had a history of childhood sexual abuse which was the precipitant for the referral, and 99 men were referred for psychotherapy who did not report a history of CSA. Of the 395 women referred, 175 had a history of childhood sexual abuse and were referred specifically for difficulties relating to this, and 220 women were referred for psychotherapy who did not report a history of CSA. All these patients completed self report questionnaires (SCL90) which are currently being analysed.

4.5.3. The above is an example of the serious under collection of statistics vital to designing services in this much needed area.

4.6. Outcomes in adult survivors of CSA

4.6.1. Adverse effects of CSA are common and serious and include psychiatric, physical health and social problems. There is not, however, a common outcome or syndrome that results from CSA. One model for understanding the interrelation between exposures and outcomes following CSA is proposed below. This model acknowledges the links between different forms of childhood abuse. While this work does not explore the relationship between CSA and other forms of trauma, including childhood physical abuse (CPA), childhood neglect or domestic violence, it is clear that there are important similarities between these types of trauma.



4.7. Risk and resilience factors

4.7.1. Well-designed studies of risk factors for CSA are rare, partly due to CSA not being reported until many years after the abuse, meaning it is difficult to measure the exposures being studied. Nonetheless some insights are available from the literature. *Finhelhor* (1986) reports on a range of risk factors, including gender, girls > boys, age at onset, step-father families. Parental substance misuse, including alcohol misuse, places the child at increased risk of CSA[20] and child abuse in general[21]. An impaired relationship between the primary caregiver and child is a potent risk factor for CSA[22-24]. Uncontrolled studies suggest that self-blame, denial or avoidance are associated with an adverse outcome[25]. Furthermore, if a mother has suffered CSA or disruption of care in her own childhood, her child is more likely to have behavioural problems if she/he experiences CSA[21]. *Finhelhor* does state however that lower socio-economic class does not increase risk, it is equal across classes.

4.7.2. Such data inevitably reflects the history of research into this complex issue. What is clear however is that responsibility for CSA lies with the abuser first and foremost; it is the abuser that presents the risk, and like other sex crimes there is no way of predicting in advance who will abuse. Risks are widespread because abusers are widespread, and children most at risk are those who have already been abused and exploited, because abusers pick them out.

4.7.3. Some factors have been shown to be protective for adult survivors of CSA. In contrast to the studies of self blame mentioned above, blame of others appears to be protective[26]. The social support of mother and child is an important protective influence. Social support from a primary caregiver, for example a non-offending mother, is related to a better prognosis[27]. 'Connectedness' acts as a protective factor for homeless people[28]. In a Canadian study of 384 adults who had experienced CSA, CPA and emotional abuse, the input of a 'very helpful professional' or service provider was found to increase self esteem and family functioning[29]. We must not forget, however, that the most important protective factor of all is prevention.

4.8. Adverse outcomes

4.8.1. Outcomes have been divided into three main groups: mental, physical health and social. The effects of CSA can be grouped into short-term[14] and long-term[30]. The short-term effects often occur during the period of abuse and are difficult to study. Long-term effects typically occur in adolescence and adulthood and there is more agreement between studies. The long-term adverse outcomes were reviewed by *Beitchman*[30] (1992). More recent evidence has been used to supplement the findings of that review.

4.8.2. Neurobiology research into the developmental and integrative aspects of the central nervous system describes changes occurring in the brain of adults who were sexually abused in childhood *Bremner et al*[65] (2003). Numerous studies using scanning techniques have reported the negative impact on parts of the brain responsible for learning, memory and processing emotions. This scientific underpinning is essential to help us understand the mechanism of early childhood trauma and more research is needed to allow this information to become clinically relevant to aid the successful treatment of survivors.

4.8.3. While some of these studies were of variable quality, the list below demonstrates the range of problems that CSA has been linked with. In each of these areas further targeted research is required.

4.9. Mental health outcomes

4.9.1. There is good evidence for an association between CSA and the following mental health problems: Anxiety[31], low self-esteem[15;32], Borderline Personality Disorder, Bulimia[15;33], Depression[15], Post Traumatic Stress Disorder (PTSD)[19;34-36] and suicide[26;37;38]. Some of these studies provide interesting additional information – adult survivors of CSA were almost twice as likely as the general population to be depressed[8], and the experience of more severe or earlier abuse were associated with a greater risk and severity of PTSD[34] and suicidal behaviour[26].

4.9.2. Survivors of CSA experience a wide range of mental health problems. One study suggests that 74% of mental illness in survivors of CSA is directly attributable to CSA[39]. The **World Health Report 2002** stated that 5-8% of self-inflected injuries, depression and alcohol, 33% of PTSD in women and 21% of PTSD in males can be attributed to CSA[3].

4.9.3. Links are being made between treatment resistant depression and a history of childhood sexual abuse. Treatment resistance is well recognised and takes a considerable toll on the individual, their use of services and the practitioners treating them. It is suggested that these patients require psychological therapies as well as pharmacotherapy. For example, *Nemeroff et al*[64] (2003) in Atlanta looked at 681 patients with chronic forms of major depression. They concluded that psychotherapy may be an essential element in the treatment of patients with chronic forms of major depression and a history of childhood trauma.

4.10. Physical health outcomes

4.10.1. There is evidence of a link between CSA and physical health problems in adult life including gastrointestinal problems, headache, obesity, pelvic pain[40], premenstrual syndrome, pseudo-seizures, psychosomatic symptoms[41-43], sexual disturbance[15] and sexually transmitted disease[44-46].

4.11. Social outcomes

4.11.1. Survivors of CSA have frequently experienced other adverse social circumstances in childhood. This can make evidence on social outcomes difficult to interpret. There is however evidence linking CSA with lower educational attainment[47], family and relationship difficulties[47-50], earlier and unsafe sexual practice[15;22;51;52], some aspects of criminal behaviour[53-55], substance misuse[15;56;57], and revictimisation[12;22;58].

4.11.2. The evidence linking CSA and future criminal behaviour is less clear than for childhood physical abuse, particularly for females[53]. Survivors in one US study had higher rates of 'sexually acting out' and runaway behaviour[54]. Another US study concluded that in comparison to childhood physical abuse and neglect, CSA did not appear to uniquely increase an individual's risk for later delinquent or adult criminal behaviour, including arrests for sex crimes and alcohol. There was, however, no control group in this study[55].

4.12. Use of health services

4.12.1. Adult survivors' use of health services can be estimated from international studies. A French study estimated that between 56-80% of female survivors of CSA experience health problems in adulthood as a consequence of CSA[59]. Using the estimate of prevalence of CSA in women of 20-25%, it can be estimated that 10-20% of the general adult female population experience health problems as a consequence of CSA.

4.12.2. A study of 1,200 women randomly selected from a health maintenance organisation (HMO) in the USA showed that, compared to women with no history of maltreatment, women who had experienced CSA had median annual health costs ($1,606) that were $245 (18%) higher than women who had not suffered childhood trauma ($1,361). CSA had a greater effect on the use of hospital services than woman who had experienced other forms of childhood trauma who had median annual health costs $97 (7%) higher than women who had not suffered childhood trauma. Women who experienced CSA also had lower perceptions of their overall health, made greater use of primary care and had more emergency admissions[60].

4.12.3. Using the estimate of excess health care costs of $245 (about £150), and the estimate that 10-20% of the general adult female population have health problems related to CSA, it can be estimated that the increased cost to hospital services in the NHS in Scotland of managing the health consequences of CSA in adult women is between £30-60 million each year.

4.13. Services for adult survivors of CSA

4.13.1 UK studies provide some insight into current services for adult survivors of CSA. 80% of medical and nursing professionals in primary care believe that CSA can result in significant health care problems, and 67% would like specific training for CSA. However, only 3-6% believe that adult patients should be screened routinely for CSA[61]. A study of staff in 47 addiction agencies in Scotland suggested that practitioners in these clinics believe that they are unequal to the task of working with clients who have been sexually abused[6]. In a study of services for male survivors of CSA, the majority of mental health professionals questioned rarely inquired about CSA in male patients and two-thirds of staff had not received specific training in the assessment/treatment of CSA[10]. A study in Edinburgh explored views of survivors and service providers (statutory and non-statutory) in mental health – the most striking finding of the report was the lack of consensus between sectors and within psychiatric services about the best way to help survivors of CSA[62].

4.13.2 A health needs assessment of adult survivors in Fife surveyed service users and service providers (statutory and non-statutory)[63]. The health needs assessment showed that most survivors do not access statutory or non-statutory services. Using the estimate that 20-25% women have experienced CSA, 14,000-28,000 women in Fife would be expected to experience complications of CSA over their lifetime. The estimated number of male and female survivors accessing voluntary services over one year was 1,200. Statutory services could not provide an equivalent estimate, and there was a wide variation in the proportion of inpatients identified as survivors in different acute psychiatric units. One unit estimated that 20% of patients were survivors of CSA while another identified only seven survivors in the previous year. Existing data from the voluntary sector may therefore provide the best idea of current service use by survivors. Non-statutory and statutory service providers identified that survivors approached services for many reasons, the most frequent were: mental ill health (76%), self-harm (71%), alcohol (58%), domestic violence (36%), homelessness (25%), abuse of another family member (23%), sexual assault (20%), and physical ill health (17%).

5. Models of Service for the Care and Treatment of Adult Survivors of Childhood Sexual Abuse

5.1. A significant problem for survivors of sexual abuse is that CSA is not widely recognised as a major contributing factor to a range of seriously disabling behaviours such as self-harm and substance abuse. It is therefore unsurprising that the emphasis in practice is largely placed upon treating the symptoms and minimising harm rather than supporting service users to explore aspects of their sexual abuse history which are problematic for them, and develop strategies for coping positively with daily life.

5.2. Most service providers are working under considerable time pressures and stress. As a consequence, they can often be reluctant to address possible underlying causes of physical, psychological or behavioural problems. A serious concern about broaching the issue of a sexual abuse history with service users or starting working on trauma issues is evident in both voluntary and statutory mainstream services. Many staff in these services do not feel sufficiently confident in their skills or supported enough emotionally to be able to ask questions that might 'open a can of worms'. Often staff are worried that they will not only do more harm than good but that there are also few specialist services available to refer service users on to if appropriate.

5.3. This problem is compounded by the difficulty many survivors have about trusting professionals enough to share their stories. Disclosure is not a one off event but a process which requires a trusting relationship built up over time. (It is important to stress that not everyone who has experienced abuse wishes to engage in further exploration or treatment and they should not feel that if they don't they are avoiding something).

5.4. Male survivors of childhood sexual abuse experience many of the same feelings and issues as female survivors. There are however particular issues that are unique to male survivors:

- Society has difficulty in recognising the fact that men can be and are sexually abused. Young males are generally brought up to believe that they are 'the stronger sex', 'the protector' and so the concept of being a victim is extremely difficult to accept. Being unable to prevent the sexual abuse can be perceived by many male survivors as a loss of their 'manhood'.
- Sexual abuse can cause heterosexual men to experience great anxiety about their sexual identity due to the mistaken belief that only gay men are sexually abused.
- There is an incorrect, but nevertheless widely held, view that men who have experienced abuse will go on to abuse children.

Issues such as these can make it very difficult for men to feel safe about going to statutory services for help.

5.5. Although this report primarily addresses the needs of those who have experienced sexual abuse in childhood, the impact sexual abuse has on particularly vulnerable groups within society should not be overlooked. Older people, those from ethnic minorities, and people with physical and learning disabilities, can and do find themselves targeted by abusers, who may be relatives, close friends or carers. Exploitation of a trusting relationship is often very difficult for a survivor to cope with, let alone report, and may be compounded by some impaired capacity. Each vulnerable group present with particular needs and require flexible and tailored responses,

but which can nonetheless be delivered within a framework of better integrated services for survivors.

5.6. Moreover, problems continue in health and social care sectors, and in criminal justice services, in responding to sexual abuse allegations, and in prosecuting perpetrators because of perceived difficulties in the credibility and reliability of the victim. **The House of Commons' Health Committee Report on Elder Abuse** (2003-04) highlights such service failings and has called for significant improvements to respond to victims' needs. In responding to the SWSI and Mental Welfare Commission reports into the care of Miss X case in the Scottish Borders, the Scottish Executive has also accepted the need for added protections for vulnerable adults.

5.7. What qualities do survivors value?

5.7.1. What, however, was of prime importance were the particular qualities staff had. Sarah Nelson highlights these qualities in her report:

5.7.2. 'Survivors described a small minority of staff from statutory, voluntary and independent sectors as tremendously helpful, or even life-changing. They were catalysts to the survivors making major improvements to their lives – for instance stopping drinking, having children returned from care, returning to university, making satisfactory personal relationships, returning to work, or freeing themselves from a lifetime of depressive illness. The characteristics of these staff, as described by survivors, were strikingly similar across the sectors – an impression confirmed when it was possible for the researchers to meet and interview them.

- They were secure and firm about boundaries, but related with warmth and kindness.
- They were informed and aware about the main effects of CSA trauma, or keen to become so, and had examined their own personal issues around working with sexual abuse.
- They worked non-hierarchically, consulting respectfully with survivors about what their main needs were and what their service could offer – trying to reach joint decisions about whether the service would be helpful, or about the work they would do together. They allowed survivors to talk about their abuse history whenever they wished, but did not pressurise them into doing so.
- They were skilful, flexible, imaginative and eclectic, sometimes 'breaking the rules' of their service in the client's interest.
- They neither hid behind confidentiality nor broke it insensitively, consulting with the client about what information ought to be shared, and what need not be.
- They did not fear to persist in asking tactfully if a client had experienced childhood sexual abuse trauma, and they had the courage to stay with clients through distressing, frightening symptoms or behaviour.
- They were prepared to work consistently over a period of time: although brief contacts had sometimes proved a dramatic catalyst to survivors changing their lives.

However

- They did not come from any one professional background or therapeutic approach and did not necessarily have high professional status, ranging from volunteer counsellor or project worker to staff nurse, social worker or consultant psychiatrist.
- A majority had not attended specific training courses on child sexual abuse, although they had gathered expertise in other ways.

- Not all had support or supervision, although all thought these were essential.' (*Nelson*, **Beyond Trauma**, (2001) p. 116)

5.8. Service models

5.8.1. The issue of access to appropriate services is important for both service users and service providers.

5.8.2. Survivors need to be sensitively supported to explore their sexual abuse history at a pace appropriate to them by staff who feel confident and who can offer safe, helpful responses to disclosure. It is usually non-specialist frontline services, dealing with issues like substance misuse, homelessness or distressed behaviour, that survivors approach first for help, or to which they are referred for 'presenting problems'. Very often however, these staff do not feel equipped to deal with the subject of childhood sexual abuse. Recipients of disclosure should be trained to avoid panic and possible unnecessary referral to specialist services, especially since many survivors do not wish constantly to be 'referred on'. This raises training issues which are picked up in more detail in the next chapter.

5.8.3. There are currently a limited number of discrete specialist services for survivors, the majority of which are provided by the voluntary sector. It is more common that projects cover other issues (e.g. rape, domestic violence) than they are discrete services. In this chapter, we give a few examples of both types of project, in the statutory and voluntary sectors. A more detailed list is available from the **Register of Services for Scotland on Violence and Abuse**, published by the Women's Support Project, Glasgow (currently being updated for 2004).

5.9. Examples in the voluntary sector

5.9.1. The *Open Secret* project in Falkirk offers individual counselling and a range of support and self-help groups to adult survivors of sexual abuse (16 plus). In Kirkcaldy, the *Kingdom Abuse Survivors Project* (KASP) offers a similar wide range of services; both these projects work with women and men. KASP offers one-to-one support, information and advice and a range of groupwork to survivors and their families, and includes a specific mental health post.

5.9.2. In Dundee, the *Eighteen and Under* project offers a range of support services(face-to-face and telephone) and information to young people under the age of 18 who have experienced sexual, physical or emotional abuse, including ritual and satanic abuse. Based in Airdrie, the *Moira Anderson Foundation* offers services, information and support to survivors, families and others affected by sexual abuse from across Scotland. It also runs a safe house.

5.9.3. In Glasgow, *Men Against Sexual Abuse* (MASA) offers telephone support and one-to-one support, while in Dundee, *M Line* offers telephone support, groupwork and one-to-one support for males. In Glasgow, *Say Women* offers accommodation and follow-on support to young women who have survived sexual abuse. The *Rape and Abuse Line* in Dingwall gives telephone support and one-to-one support to both women and men. *Health in Mind*, Edinburgh provides dedicated services of counselling, groupwork and one-to-one support to survivors. The majority of voluntary sector projects also offer training to a wide range of agencies.

5.9.4. In some voluntary sector projects, sexual abuse work is prominent but other issues including other sexual violence, domestic violence or prostitution are also covered. Such projects include the *Women's Support Project* in Glasgow, *Edinburgh Women's Rape and Sexual Abuse Centre*, and the Scottish network of *Rape Crisis Centres*.

5.9.5. The *Central Scotland Rape Crisis Centre* in Stirling works on the principle of not concentrating on the particular abuse but in raising the self-esteem and worth of survivors to help them make sense of how their experience has/is affecting their lives, while respecting their rights as individuals and empowering them to make their own choices as to what is best for them in their life. The *South West Rape Crisis & Sexual Abuse Centre* offers face-to-face counselling, an outreach service, and run a refuge.

5.9.6 *Breathing Space*, currently covering the West of Scotland, is a freephone service for people with depression or low mood. *Wounded Wings*, Edinburgh is a support project for self-harming people, many of whom are abuse survivors.

5.9.7 *Stop it Now* is a UK-wide project that provides telephone advice to people at risk of perpetrating abuse on children, their friends and relatives. They have been able to encourage people to go to the police rather than wait to be caught.

5.10. Examples in the statutory sector

5.10.1. In the statutory sector some psychiatric hospitals or units run special programmes to help survivors address issues arising from their abuse. For instance nurse-led, modified Cognitive Behavioural Therapy (CBT) programmes and longer-term work with complex trauma are available at St John's Hospital Livingston, while longer-term nurse-led work with complex trauma is available at Cambridge Street Day Hospital in Edinburgh. Most psychotherapy departments receive a significant proportion of referrals with a history of childhood sexual abuse and will offer individual and group outpatient psychotherapy as appropriate. These services are not seen as being specific to CSA but are in response to the demand of the clinical population and might benefit from more coordinated contact with other agencies to facilitate an integrated programme of intervention addressing complex needs.

5.10.2. Other statutory projects feature sexual abuse prominently but also cover a wider range of issues. For instance the *Eva Project* in Coatbridge, a health initiative, covers all areas of male violence against women and offers a range of services including information and advice, counselling, and advocacy. *The Centre for Women's Health* in Glasgow, another health initiative, offers one-to-one and group support, drop-in and library facilities, among other services. The sexual abuse service run by the Psychotherapy staff based at the *Lansdowne Clinic* in Glasgow offers therapy and counselling to survivors, and support to counsellors themselves. *Breakthrough for Women* in Glasgow, a social work initiative, provides support, counselling and information, includes counsellors with a range of ethnic minority languages and covers rape, sexual abuse and abuse through prostitution. The *Sexual Abuse/Sexual Assault Clinic* based at Stobhill Hospital in Glasgow has been providing a multi-disciplinary therapy service to women and men for 10 years. This includes an innovative dual-problems clinic for people with substance misuse and history of sexual abuse/assault. They also provide consultancy and training support to staff.

5.10.3. Despite their statutory basis, some of these services do not receive dedicated funding, sometimes relying on underspends to continue operating. This creates real uncertainty for staff, and inhibits forward planning. Some NHS boards offer, or are in process of establishing, multi-disciplinary teams who do specialist work with people with complex trauma symptoms (e.g. heavy substance misuse, suicidal and self-harming behaviour). Many of these are sexual abuse survivors. One example is Ayrshire & Arran NHS Board which has a residential unit and care programmes run by teams that include psychiatrists, community psychiatric nurses, occupational therapists and social workers.