ASKING THE QUESTION ABOUT VIOLENCE AND ABUSE IN ADULT MENTAL HEALTH ASSESSMENTS

A FOCUS ON CHILD SEXUAL ABUSE

Trainers' Notes

DH Department of Health

National Institute for Mental Health in England

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Introduction

These training materials are based on a course developed over many years by Chris Holley, Consultant Nurse, Sexual Abuse & Women's Issues, South Staffordshire & Shropshire Healthcare NHS Foundation Trust. This version of the course has been refined following the experience of fifteen pilot trusts that participated in the Mental Health Trusts Collaboration Project between September 2006 and September 2008. The pilot was extensively evaluated and the evaluation team, DMSS Research and Consultancy, has produced this final set of materials based on the observations of courses and feedback from trainers and participants.

About these notes

These notes are intended to be used in conjunction with the PowerPoint presentation provided. Underneath a copy of each slide in the presentation, they comprise:

- A 'script' which appears between speech marks (" "). This is not intended to be read out but is provided as a 'crib sheet' for new trainers, and for those occasions when you've forgotten what you were going to say next (it happens to all of us!).
- Instructions in **bold.**
- Additional information for trainers, references and links to useful websites in *italics*. Most of these references are also included in the Course Reader for participants which supplements the content of the one day course curriculum.

Suggested timings are inserted on the Course Programme overleaf; they're also similarly highlighted within the trainers' instructions. These timings assume a start time of 9.30 am, a mid-morning refreshment break, an hour for lunch, a mid-afternoon break and a finish time of 5.00 pm at the latest.

There are two slides with title only, towards the end of the presentation, where you will need to insert information specific to your locality and your trust:

- No. 46: Local voluntary sector services – listing relevant specialist services provided by this sector to enable staff to facilitate survivors' access to them, if they so wish.

- No. 57: Local support to staff – should include the trust's confidential counselling service (in relation to staff who are survivors); identified practitioners who can provide case consultation on sexual abuse; your Safeguarding Leads.

These notes make reference to the numbered case examples included in your Trainers' Manual. We have included them where an example is recommended to illustrate a point. Case examples are important as they bring the issues alive and help participants connect with the lived experience of survivors. However, don't feel that you have to use all the examples – be selective. Some cases are referred to more than once because they illustrate more than one point – you can choose if and when to use them. The only exceptions are Nos. 16 and 17 relating to race and disability which should be retained unless you can replace them with your own examples.

Where you do have your own case material which illustrates the same points as the case examples provided, it's usually better to use these as you are likely to recount them more easily. Do remember, however, to make sure they are sufficiently disguised to ensure client confidentiality.

Every participant needs to have access to the Course Reader specifically for use *after* the course. It's important that participants focus on *your* delivery of the course without referring to other documents i.e. 'flicking through' the Course Reader (and that they stay for the whole day). The most cost-effective and efficient method of doing this is for the Training Department (or responsible Administrator) to email a copy to each participant *after* they have completed the course. A copy of the Course Reader is also included in your Trainers' Manual.

Here's a checklist of information you'll need on the day, as cited in these Trainers' Notes:

- Attendance sheet
- Copy of each of the 'Breaking Free' publications
- Copy of your local Safeguarding Children and Adults Procedures
- Copy of 'Practice Guidelines: Provision of Therapy for Vulnerable or Intimidated Adult Witnesses Prior to a Criminal Trial'
- Specifically designed post-training evaluation forms to be completed by participants *before* they leave at the end of the day
- Certificate of attendance for participants

Also it's advisable to familiarise yourself with the following before you start training, as cited in these Trainers' Notes:

- Your local Safeguarding Children and Adults Procedures (as mentioned above)
- Practice Guidelines relating to a Criminal Trial (as mentioned above)
- Your trust's complaints and whistle-blowing procedures in case you are asked questions related to abuse disclosures perpetrated by mental health professionals
- The means by which your trust will provide professional development opportunities – for participants to further enhance their clinical expertise in sexual abuse, e.g. a regular Practice Development Forum; quarterly clinical seminars

With regard to issues relating to service users and/or staff from Black and minority ethnic communities, some of these are highlighted within the course curriculum. In addition, relevant colleagues within your trust need to consider the range of pertinent issues – in conjunction with both staff and service users of different ethnic and cultural backgrounds – on an ongoing basis.

Last, but not least, survivors' testimonies are very powerful and there are many ways of encouraging staff to connect with these. Recommend that course participants read the Service User Audit findings in the Course Reader and/or suggest autobiographies that you've found helpful.

A 45 minute DVD – '*Not Mad or Bad or Traumatised'** – comprises testimony from a number of survivors of child sexual abuse who are also users of mental health services. It was produced in 2008 by CIS'ters, in conjunction with NIMHE South East Development Centre, and a copy has been sent to the Chief Executive of every mental health trust in England. It can be viewed by individual staff or teams as part of continuous professional development.

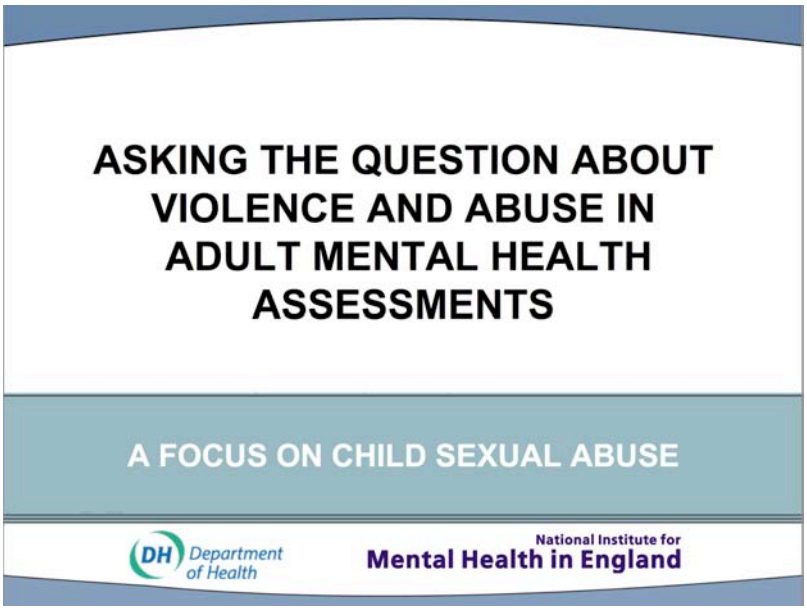
Good luck!

***CIS'ters SEDC – NIMHE**, PO Box 119 3000, Cathedral Hill, Eastleigh, Guildford, Surrey SO50 9ZF **Tel:** 02380 338080 **Tel:** 01483 243552*
Email: *admin@cisters.wanadoo.co.uk*

Course programme

9.30 am	**Introduction to the day**
9.35 am	**1. Before we begin…**
9.45 am	**2. Context of the course** Routine exploration of abuse in mental health assessments National and local policy context Course focus on child sexual abuse
9.55 am	**3. About child sexual abuse** History Definitions Prevalence Relevance for adult mental health services
10.15 am	**4. Common issues for survivors** Finkelhor's 4 Factor Model Correcting the myth: '50% of victims become abusers'
11.00 am	**Mid-morning break**
11.15 am	Why did it happen to me? Could I have prevented it? Will I become an abuser? Why didn't I tell?
12.30 pm	**Lunch**
1.30 pm	Why has it affected me like this?
2.10 pm	**5. Issues for staff in hearing about abuse** Fears and anxieties Attitudes to sex and sexuality Sexual language
2.45 pm	**Mid-afternoon break**
3.00 pm	**6. Asking the question and hearing a disclosure** Why adults don't tell The impact of disclosure Asking the question Trial run
4.30 pm	**7. After disclosure** Therapeutic support for survivors of abuse Support for staff
4.45 pm	**8. Debriefing** Lessons learnt Post-training evaluation

Slide 1



The purpose of the day is to help people get comfortable with the idea of asking about experiences of violence and abuse in their assessments. The expectation is that, if they don't already, they will begin to ask the question following the training.

We know that the biggest block to asking is that many staff fear a disclosure of sexual abuse. Those who feel ill-equipped to say or do the right thing would therefore rather avoid the subject. That is why the course focuses on *child sexual abuse.* It does not attempt to deal with other kinds of child abuse or with domestic or sexual violence, although these are equally important determinants of mental health.

Today you will make clear to participants that violence and abuse are part of the core business of mental health services. They are not an optional specialist interest, or issues to be passed on to colleagues in psychology or in the voluntary sector. This is not about 'new work' – nearly half of the women service users they currently work with and over a quarter of the men will have experienced sexual abuse in their childhood – but about recognising that survivors' needs have largely gone unmet by mental health services.

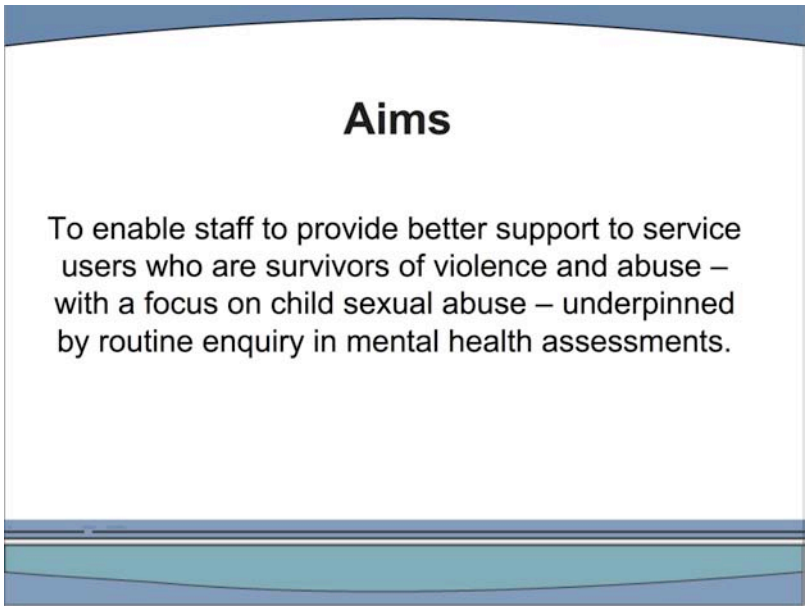
Participants will gain a clear sense of why child sexual abuse has profound impacts on mental health in some cases, and only minor ones in others. They will appreciate that service users with a wide range of diagnoses can have sexual abuse as an underlying issue.

They will go away with a better understanding of some of the common questions survivors struggle with such as *"Why me?"* and *"Will I become an abuser?"* and some well-evidenced answers which they can pass on to survivors. The fact that not all survivors need or want formal therapy, and that all mental health staff have an important role to play in providing the support survivors require, will be clear.

Participants will also have been introduced to a couple of simple tools (the Safety Model and the Respond Tree) that they can use in their direct work with survivors. You will have brought to their attention the 'Breaking Free' publications to further assist them in supporting survivors. (Hopefully your trust will make arrangements for every team to have a copy of these.) They will have been strongly encouraged to use support, supervision, reading and further training to develop their understanding and their skills.

Introduction to the day

Slide 2: Time – 9.30 am



"Welcome everybody. Before we go into introductions, just to clarify the Aim of the course, which is to improve the support we provide to survivors in our care, focusing on child sexual abuse, underpinned by routinely asking about all forms of abuse in assessments.

This training course is based on one developed by Chris Holley, a Consultant Nurse in South Staffordshire* who has been providing training on sexual abuse to mental

health staff since the early 1990s. It draws on the work of Kay Toon and Carolyn Ainscough who wrote 'Breaking Free' and the 'Breaking Free Workbook'.** Their books are included in the suggested reading list in your Course Reader. This course was piloted in fifteen mental health trusts between 2006 and 2008, independently evaluated and due revisions have been made to the course we're delivering today.***

During this morning, we'll be looking at the context of routine enquiry, facts about child sexual abuse, common issues for survivors – why did it happen to me?, why didn't I tell?, why has it affected me like this? – including an Offending Model, to understand in more detail the interplay between survivors and their abusers.

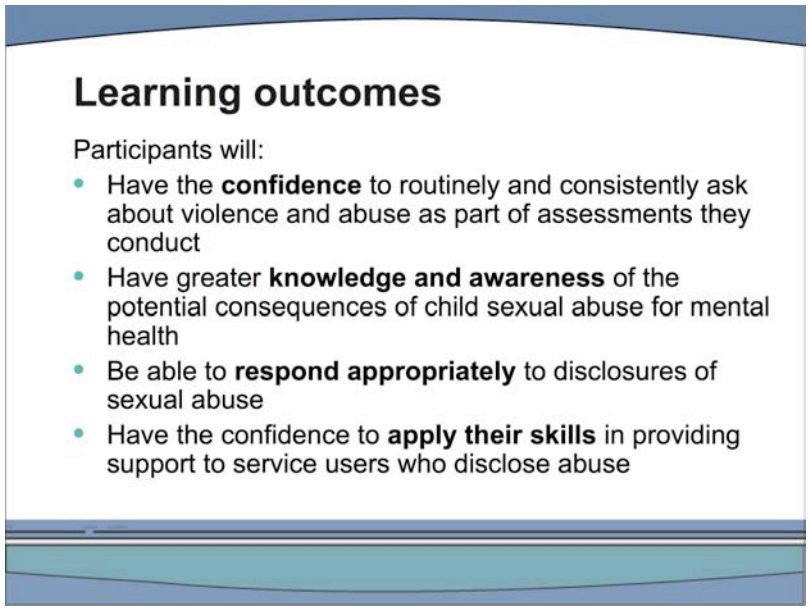
In the afternoon, we then move on to issues for staff in hearing about abuse, concentrating on the specifics of asking the question, hearing a disclosure and the ways you can provide ongoing therapeutic support for your clients who are survivors."

** Chris Holley, Consultant Nurse: Sexual Abuse & Women's Issues, South Staffordshire & Shropshire Healthcare NHS Foundation Trust*

*** Ainscough, Carolyn and Toon, Kay (1993)* ***Breaking Free: A Self Help Book for Adults who were Sexually Abused as Children,*** *Sheldon Press, new edition 2000; Ainscough, Carolyn and Toon, Kay (2000)* ***Breaking Free Workbook****, Sheldon Press.*

**** McNeish, Di and Scott, Sara, Mental Health Trusts Collaboration Project: Meeting the needs of survivors of abuse, overview of evaluation findings, September 2006 to July 2008, www.dmss.co.uk*

Slide 3



"These are the learning outcomes for today. The course is intended to give you the confidence to ask the question about violence and abuse in all mental health assessments.

The reason we are focusing on child sexual abuse is because this is the area that staff often have least confidence in addressing.* However, many of the issues we will be discussing today also apply to emotional and physical abuse. The course is not intended to teach you new therapeutic skills. You already have the skills you need to respond appropriately to survivors of abuse. By the end of the day we hope you will feel more confident to use them.

Some of you may have considerable expertise in working with survivors of abuse. For others, this will be the start of your learning, but it is important that everybody receives the same training so that we share a common understanding of the purpose of routine exploration."

**If participants need further justification, point them to the findings of Penny Stafford's Staff Service Audit 2007; an executive report is in their Course Reader.*

Section 1. Before we begin….

Slide 4: Time – 9.35 am

- **Trainers need to introduce themselves with some information about their professional background and relevant experience.**
- **Trainers should then invite participants to introduce themselves. It can be useful to ask participants to say what expectations and concerns they have about the day. This provides an opportunity to 'surface' any issues and make sure they are addressed during the course of the day.**
- **Give times of breaks for lunch, tea-breaks and end time. Cover location of toilets, fire procedures etc. Emphasise that participants need to stay for the whole day.**
- **You need to cover issues of confidentiality and acknowledge that there may well be survivors of abuse in the room.**

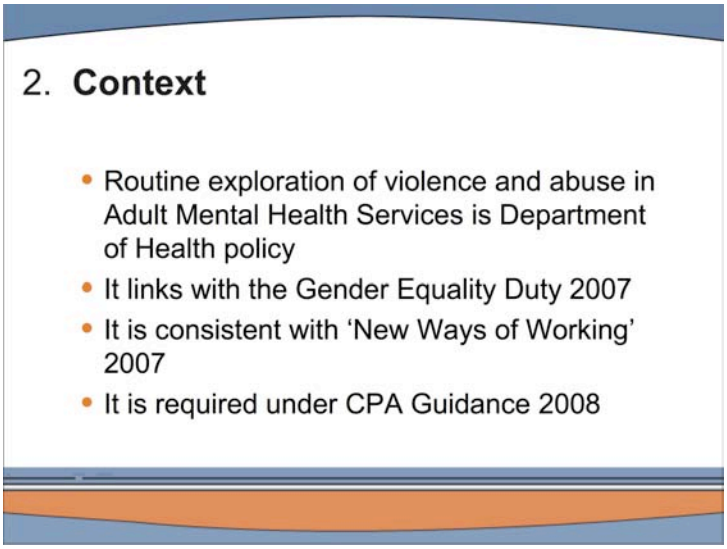
"Child sexual abuse is a sensitive topic and some of the material we cover today is, by its nature, explicit, and you may find parts of it distressing. It is therefore important that you look after yourselves during the day. The chances are that there will be people in the room with personal experience of abuse, so please be sensitive to that during our discussions.

If anybody needs to take time out, please do so. Just come back when you're ready. If, after today, there are any outstanding issues for you, then we would encourage you to talk to a colleague, supervisor or line manager.

We will be using case examples during the course of the day which are anonymised. If you want to share examples from your own experience we welcome that, but please ensure you do this in a way which protects the confidentiality of the service user concerned."

Section 2. Context

Slide 5: Time – 9.45 am



"The background to the initiative originates in the Implementation Guidance: Mainstreaming Gender & Women's Mental Health, DH 2003. Although this was in the context of the development of women's mental health services, Department of Health policy makes it clear that the question should be asked of both women and men.

Of course, the issue is relevant in all services that mental health trusts deliver, including those for older people, those with learning disabilities etc. The expectation is that the process will move into these services in due course.

From April 2007 the Gender Equality Duty required public bodies to promote equality between women and men, by having policies and procedures in place which take account of their different needs.* The Equalities Bill, legislation planned for 2009, will establish a single Equality Duty requirement incorporating all equalities.**

New Ways of Working*** aims to ensure that services provide high-quality, person-centred, effective services by creating 'Capable Teams' who work with the service user as a whole person, not as a set of symptoms."

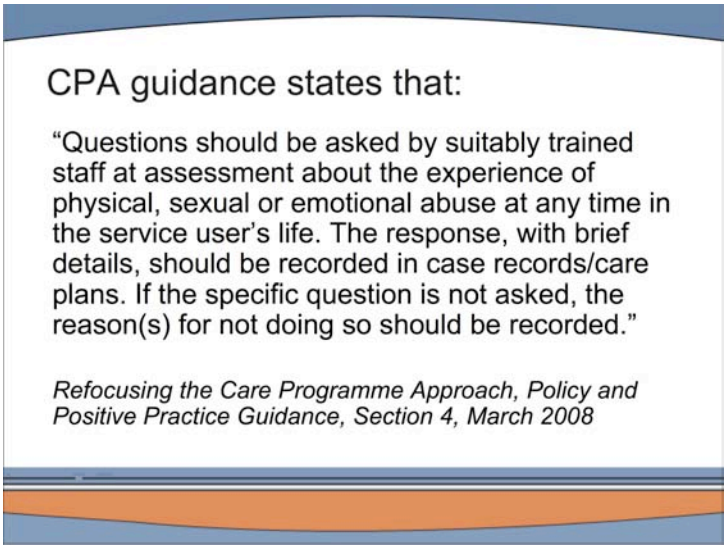
** To find out more about the Gender Equality Duty, visit:*
www.equalityhumanrights.com/en/forbusinessesandorganisation/publicauthorities/gender_equality_duty/pages/introduction_genderduty.aspx

*** To find out more about the Single Equality Duty, visit:*
www.publications.parliament.uk/pa/cm200405/cmbills/072 /2005072.htm

*** To find out more about New Ways of Working, visit: www.newwaysofworking.org.uk/

See also ***Informed Gender Practice: Mental Health Acute Care that works for women,*** NIMHE/CSIP, 2008 at www.nimhe.csip.org.uk/our-work/gender-and-womens-mental-health.html?keywords=Informed gender practice

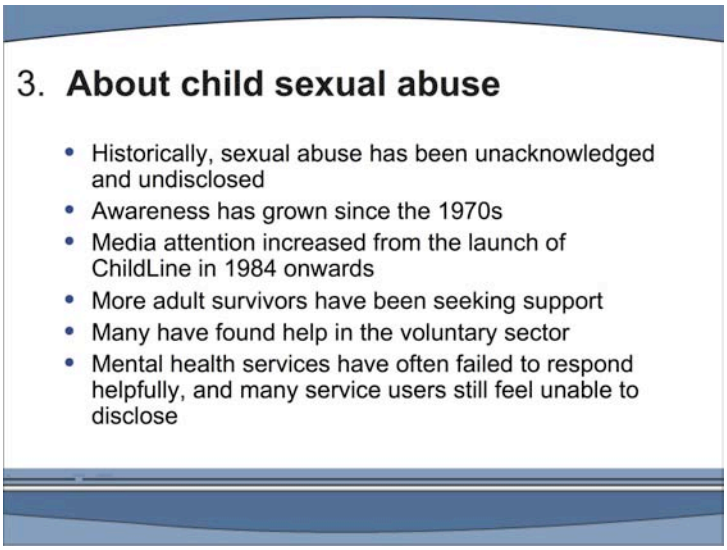
Slide 6



You may wish to mention that a slide, later in the day, shows how the question should be presented in assessment documentation.

Section 3. About child sexual abuse

Slide 7: Time – 9.55 am



"Sexual abuse has always existed. However, it wasn't until the Women's Movement in the 1970s that it began to be widely talked and written about. It didn't receive much media attention until the 1980s. A key influence was Esther Rantzen's 'That's Life' programme on Sunday nights which brought the issue of sexual abuse into our homes. Out of this ChildLine was born. Today the topic regularly features in soap story lines, on talk shows and in numerous autobiographies and self-help books.

As awareness has increased, so has the number of people seeking support for their abusive experiences. Much of this support has been provided by the voluntary sector. A network of Rape Crisis Centres and survivors groups has provided support in the voluntary sector since the late 70s and, today, The Survivors Trust is an umbrella organisation which embraces more than 80 voluntary services.*

Whilst there have been mental health practitioners working in this area for many years, the extent to which survivors have been appropriately supported within statutory services has varied considerably. Many service users have described negative and unhelpful responses from mental health services. Few practitioners have had any formal training on sexual abuse. This is the deficit that current policy – and this training – is intended to address."

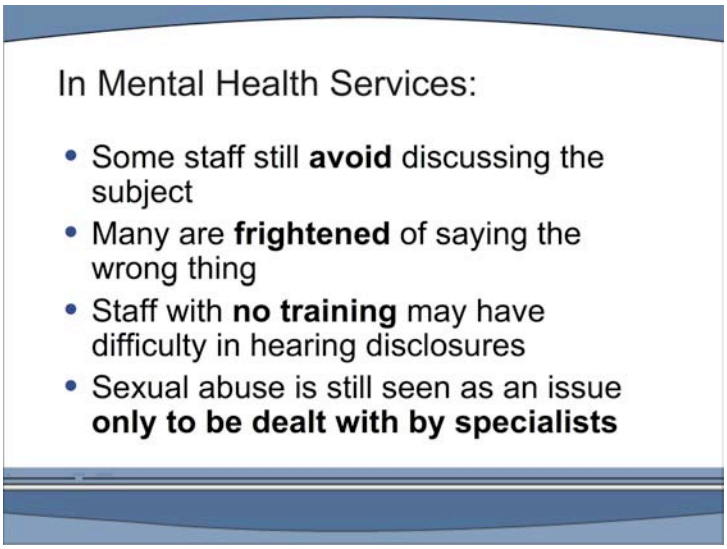
At this point trainers can ask participants how many of them received any formal training on abuse as part of their professional training. This generally illustrates the point very well. You may also want to draw their attention to the report by Penny Stafford, which is based on the views of survivors and which they will find in their Course Reader.**

"The aim of this training is to improve the service that survivors receive from mental health services, and ensure that they are able to fulfil their responsibility for meeting the needs of adult survivors on their caseloads. Of course service users have choices and may wish to use voluntary sector provision, and therefore it's important that your teams are aware of services in this sector. However, practitioners should not simply refer on their responsibilities to the voluntary sector. This is core business for us within mental health services."

** www.survivorstrust.org.uk includes a directory of services around the country and useful self-help information.*

*** Penny Stafford (2007) Service user consultation report, Walkerhill Consultancy Service.*

Slide 8



First read out the bullet points on the slide.

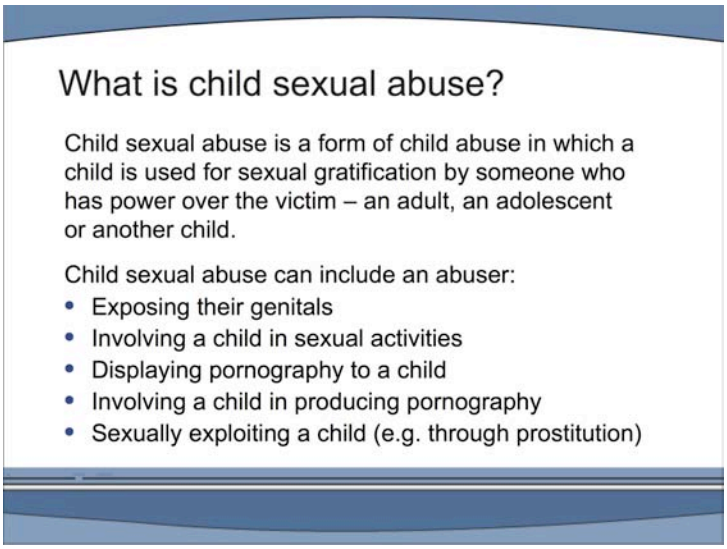
"The growth in awareness of sexual abuse means that many service users arrive at mental health services expecting to be asked about their history of abuse. As a society, we're generally much more prepared to talk about sexual abuse – and that goes for survivors too.* However, mental health professionals generally don't discuss sexual abuse with their clients easily. Some of this is to due to a lack of knowledge, so an increased understanding is likely to increase confidence. This is one of the main purposes of today's course."

Case example 1 illustrates the implications of staff avoidance for service users.

You may wish to pause at this point and check out that everyone is clear so far about the purpose and context of the day, before going on to define child sexual abuse.

** If trainees want evidence that survivors want to be asked about abuse in mental health assessments, refer them to the study by Sarah Nelson, a research fellow at Edinburgh University. Nelson, S (2001)* ***Beyond Trauma: Mental health care needs of women who survived childhood sexual abuse,*** *Edinburgh: Health in Mind. Sarah wrote one of the first UK books to be published on the subject of sexual abuse:* ***Incest: Fact and Myth,*** *Glasgow: Stramullion (1982).*

Slide 9



"This is a fairly standard definition of child sexual abuse. However, how people define abuse varies. If a 17-year-old has sex with his 15-year-old girlfriend, is that sexual abuse? Always? Sometimes? If he is 19? 22?

Legislation relating to sex and sexual offences varies from country to country. In Spain, for example, the age of consent is 13 (14 in Italy, 17 in Texas and 20 in Tunisia) reflecting prevailing attitudes towards young people and sex in those different societies.

In addition, what counts as sexually abusive is culturally variable. Female genital mutilation is illegal in this country but still quite widely practised in the name of custom, religion and hygiene in several African countries, particularly Egypt, Ethiopia, Somalia and the Sudan.*

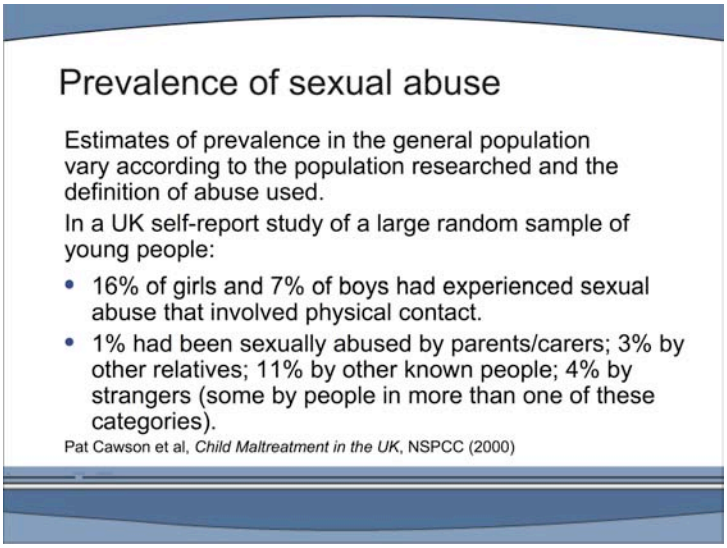
People's experience and understanding of what has happened to them (including whether they name it as abuse or not) varies a great deal. It is important to remember this, particularly when working with clients whose background or culture differs from your own."

Relevant colleagues within your trust will need to consider the range of pertinent issues – in conjunction with both staff and services users of different ethnic and cultural backgrounds – on an ongoing basis.

** For further information on FGM see Forward website: www.forwarduk.org.uk*

The Royal College of Nursing educational resource on FGM is available at: www.rcn.org.uk/__data/assets/pdf_file/0012/78699/003037.pdf

Slide 10



"It is extremely hard to estimate prevalence, not least because respondents may be reluctant to disclose their experiences to a researcher. In addition, different studies have defined sexual abuse differently (including or excluding non-contact abuse such as 'flashing' or making a child watch pornography, for example).

Studies have used different data collection techniques (including questionnaires, telephone surveys and life-history interviews), different samples and different age cut-offs (under 18, under 16 and under 13 being the most common). Not surprisingly, therefore, estimates vary from between 3% and 36% of girls and between 3% and 19% for boys*.

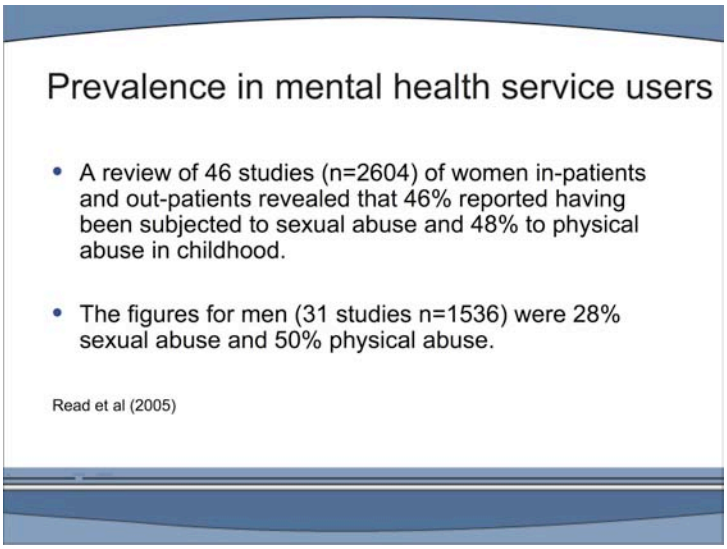
Because prevalence studies rely on respondents' willingness to disclose, it is likely that they under-estimate some kinds of abuse and some categories of victim e.g. boys. However, most estimates agree that girls are generally at greater risk than boys; we will come back to this later in the day. Gender differences are also indicated in terms of likely age and relationship with their abuser or abusers; girls being more at risk at a younger age and in familial settings, and boys at an older age and in non-familial settings."

** The NSPCC study is the largest and most recent study of child maltreatment. Confidential questionnaires were completed by 2,869 18- to 24-year-olds. In making sense of prevalence, it may help to know that the child population (18 years and under) of the UK is approximately 14 million (Office for National Statistics 2006), so even 1% of this represents 140,000 children and young people:*

Cawson, Pat, Wattam, Corinne, Brooker, Sue and Kelly, Graham (2000) ***Child Maltreatment in the United Kingdom: a Study of the Prevalence of Abuse and Neglect****, NSPCC.*
www.nspcc.org.uk/Inform/research/Findings/researchfindings

For a discussion of the wide range of estimates see Finkelhor, David (1994) 'The International Epidemiology of Child Sexual Abuse' in ***Child Abuse and Neglect****, 18 (5).*

Slide 11



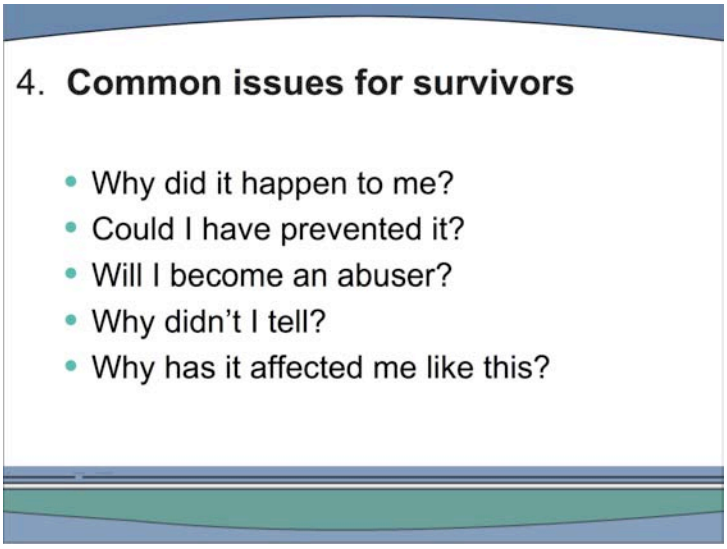
"It is likely that just under half of the women and over one-quarter of the men you work with will have been sexually abused in childhood*. These figures make it quite clear that abuse should be part of the 'core business' of mental health services. Given this, we need to understand some of the key issues for survivors in our services."

You may wish to add that, once consistent routine enquiry is established, a much more accurate picture will emerge, but of course we do know that prevalent studies are likely to be an underestimate.

** Read, J, van Os, J, Morrison, A et al (2005) 'Childhood trauma, psychosis and schizophrenia: A literature review with theoretical and clinical implications' in* ***Acta Psychiatrica Scandinavia****, 112, pp. 330-350.*

Section 4. Common issues for survivors

Slide 12: Time – 10.15 am



"Many survivors of child sexual abuse share these anxieties and questions. These are some of the issues they commonly need to talk through after disclosure, so this section of the course provides you with some information you can share with survivors to address their questions and dispel some myths.

The material may be very familiar to some people in the room and not at all to others. Remember that the purpose of presenting it here is to ensure that *all* staff in mental health services are confident they have the same basic knowledge that will enable them to respond helpfully to someone who discloses sexual abuse.

Survivors often believe that they ought to have been able to protect themselves. They feel that they should have known that the person who abused them presented a risk. However, we know that abusers come from all walks of life. They may be family members or hold positions of trust and care* in relation to the children they abuse. Some abusers are women, although research suggests that 90% or more child sexual abusers are men. **

When survivors ask "*Why me?"* it can help to explain that abusers typically choose the children they target carefully, in order to minimise the risk to themselves: they often choose children who are vulnerable in some way because they lack support or attention, are having problems at home or are lonely and lacking in confidence with their peers.

The model I'm going to share with you now can help survivors understand that abusers are very deliberate and well planned in carrying out their abuse, and that they were unlikely to have been their abuser's only victim."

** The Sexual Offences Act 2003 contains specific offences that relate to breach of trust by care-workers, specifically including engaging in sexual activity with someone with a mental disorder.*

A Home Office leaflet is available at:
www.popan.org.uk/policy/Policy_content/sexual%20offences/care_workers.pdf

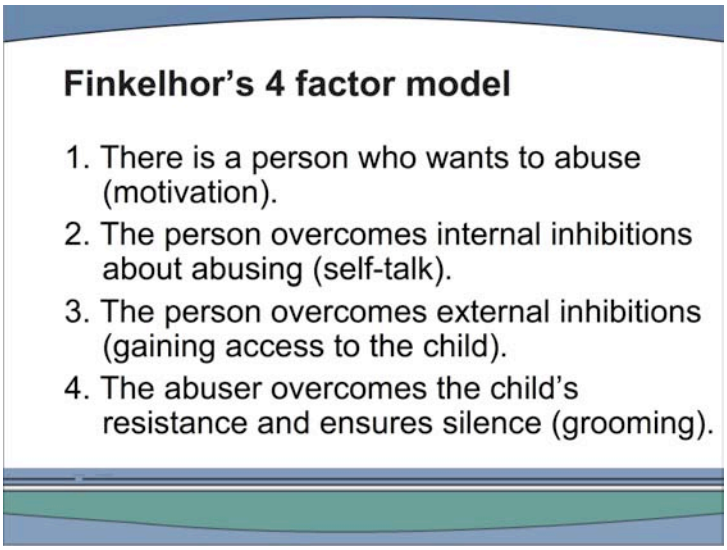
Staff can obtain information and support from the WITNESS helpline: 08454 500300, www.popan.org.uk

*** For more information on abusers see Finkelhor, David (1984)* ***Child Sexual Abuse: new theory and research****, New York Free Press. For further reading on women abusers see Saradjin, Jacqui (1996)* ***Women who sexually abuse children: from research to clinical practice****, Chichester: John Wiley.*

In one study of over 10,000 non-incarcerated, male child molesters, the men closely matched the demographics of the general male population in marriage status, education, employment, religiosity, and ethnicity. 70% of the men who had molested boys identified as exclusively or predominantly heterosexual in their adult sexual preferences.

The same study reported that amongst extra-familial child molesters, those who abused girls had an average of 52 victims each. Those who abused boys, while less common, averaged 150 victims each. Gene Abel and Nora Harlow, The Abel and Harlow Child Molestation Prevention Study at: www.childmolestationprevention.org

Slide 13



When this slide first appears on the screen, the audience will only see the title.

First read out the following:

"David Finkelhor, one of the most prominent researchers on child abuse, has proposed that four preconditions must exist for sexual abuse to take place:

Click the mouse once for Factor 1 to appear, then read the following:
To understand this model it might be helpful to think about the analogy of a burglary. So allow yourself to fantasise about the perfect burglary. Such fantasies are quite common. Most of us don't go on to carry them out – our consciences or the fear of getting caught stops us.

Similarly with sexual abuse, it has to start with someone who has a desire to commit a sexual act with a child – a fantasy. These fantasies, as long as they stay as fantasies, are not illegal. Many people will stop themselves from ever enacting their fantasies with a real child.

And in the same way that thieves can lean towards different types of crime – car theft, house burglary, factory burglary, garden sheds and so on – sex offenders can also have preferences... for victims of a particular age, for boys or girls or a specific sexual act, irrespective of the age or sex of their victims. However it is dangerous to presume that, if an offender is known to have targeted boys in the past, girls are safe from abuse, and vice versa; this is an assumption too often made.

For example, CEOP (Child Exploitation and On-line Protection Centre) successfully investigated a case in which a male abuser solely downloaded images of young boys. His real-life victim was female – his niece – because she was accessible.

Click the mouse again for:

Factor 2

So what would need to happen to enable someone to start to enact their fantasy? Well, if I was the would-be burglar I might tell myself that the people who owned the house in the next street were rich enough to afford to replace anything I stole, they probably would hardly miss it. In any case, they'd claim it all back on the insurance – I'd even be doing them a favour!

The person with the sexual abuse fantasy also has to indulge in this kind of self-talk to overcome their inhibitions. The assumption is that everybody has inhibitions in relation to sex with children. Everyone is inhibited by social, moral or psychological factors (e.g. incest taboos). But abusers find ways to overcome these inhibitions. Alcohol consumption is, in many cases, a key factor which allows abusers to overcome inhibitions.

In addition, they might tell themselves that they wouldn't really hurt the child, they'd only be expressing their love for the child and it's obviously better for the child to experience sex from someone who loves them. Or they may tell themselves the child deserved it or was 'asking for it'. And, in any case, it can't be all that wrong because lots of other people have the same kinds of fantasy – it's all on the Internet.

Previously most sex offenders had little or no contact with others unless they were prosecuted and met them in prison. Now, however, access to images of the sexual abuse of children and to actual and potential offenders around the world is unlimited. We do not yet know how this has impacted on the fantasies, inhibitions or actions of offenders and potential offenders.

Click the mouse again for:

Factor 3

Once I've convinced myself that burgling a house isn't really wrong, I need to find the right house to break into. I'd look for one with easy access, one where the owners were away a lot, with no alarm etc. I might take quite a long time over this to make sure I've chosen the right place to burgle. I'd stake the place out for a while to be certain of all the risks and how I'm going to get around them.

Similarly, a sex offender who wants to commit abuse and get away with it will target children who are easy to access. The person may befriend an existing family, perhaps targeting a single woman with children. They may look for a job with children and, perhaps easiest of all in terms of access, they might start abusing their own children."

You may want to ask the group at this stage what kind of role – paid or voluntary – gives someone access to children in a trusted, unsupervised position.

Finally, click the mouse to bring up:
Factor 4
"To commit the perfect burglary, I'll need to get into the house I've selected quietly and unseen. Ideally I'll take what I want in such a way that it will be a long time before it's missed. In the meantime I'll establish an alibi and behave in a way to place myself above suspicion. This is the most risky part of the burglary process – the 'doing it and getting away with it' stage. Careful planning is required.

A sex offender will do the same. Many are likely to take their time to win the trust of the child, to groom them into accepting the abuse. The abuse itself may start very gradually so the child is less likely to tell anyone. Abusers often have extraordinary 'radar' for a child's emotional vulnerabilities, dependencies and loyalties. Abusers often begin relationships with nurture and support and only gradually introduce abusive behaviours.

Other abusers use threats or actual violence to silence a child from the outset. They may threaten the child with specific consequences of telling, such as: *"You'll be taken into care if anyone finds out about this"* or *"No-one will believe you… you're always telling lies".*

Note the emphasis on overcoming a child's resistance. People who have been abused often struggle with 'their role' or 'their part' in the abuse: *Maybe I didn't resist enough; Why didn't I tell someone sooner*?; maybe there were pleasurable elements to the activity.

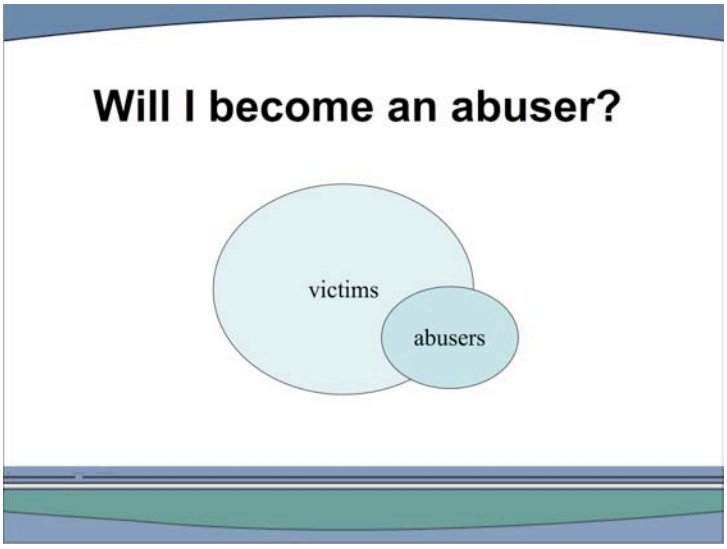
Knowing how abusers think and operate can be very helpful to a survivor's recovery; for example, understanding how they were targeted, why they weren't able to tell and, in particular, if they are worried about becoming an abuser themselves."

Case example 2 illustrates how an offender targets and grooms potential victims.

Finkelhor suggests that there are three components to the motivation to abuse: ***emotional congruence*** *(sexual interaction with a child must somehow 'make emotional sense' in the experience of the abuser);* ***sexual arousal*** *(the abuser-to-be must experience interactions with children as a potential path to sexual gratification);* ***blockage*** *(other sources of sexual gratification are either unavailable or experienced as less satisfying).*

For a full explanation of Finkelhor's model see: Finkelhor, David and Araji, Sharon (1986) 'Explanation of Pedophilia: A Four Factor Model' in ***Journal of Sex Research*** *22:2, pp. 145-161.*

Slide 14



"Research based on interviews with convicted sex offenders has found that around 50% of those who have abused a child *claim* that they were themselves sexually abused in childhood. These findings have been widely reported, and have led to a serious misunderstanding by many members of the public and survivors themselves – that 50% of children who are abused will grow up to abuse others.

This diagram shows how inaccurate this belief is. While you can see that half of the abusers are also victims of abuse, only a small proportion of all victims are also abusers. If there were some simple causal relationship between being abused and becoming an abuser, there would be a much greater number of women sexually abusing children. In fact, studies suggest that only between 5 and 10% of such abusers are women.* Also remember that some abusers abuse dozens of children in their life-time; so for every abuser there are likely to be many more victims."

The following exercise is a way of visually demonstrating the point. It works well for those who find the verbal description hard to follow:

- **Ask three participants to come and stand next to you.**
- **Describe the four of you as representing *the population of sex offenders.***
- **Describe all the other participants in the room as representing *the population of survivors of sexual abuse.***

- **Identify two members of the 'offenders' group as having also been victims of sexual abuse. These now represent the *50% of convicted sex offenders in the research who say they were themselves abused as children.***

- **Now ask these two to sit back down with the other participants**

- **Point out that the two *previously identified offenders are now in a different group – of survivors of sexual abuse* – and that, as sex offenders, they now represent – not 50% of survivors – but only a small proportion of the much larger group.**

- **Ask the group if the demonstration has made the common misconception about victims becoming offenders clear. DON'T MOVE ON UNTIL YOU ARE SURE PARTICIPANTS HAVE UNDERSTOOD THE POINT YOU ARE MAKING.**

"The clear message from research is that the majority of victims of sexual abuse, including the majority of male victims, do not go on to sexually abuse others." **

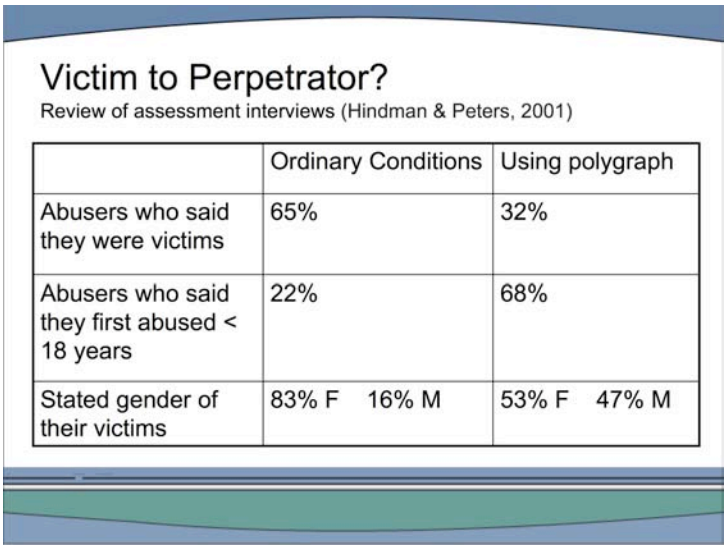
This may be a good time for the mid-morning break (11.00 am).

** Finkelhor, D (1984) **Child Sexual Abuse: New Theory and Research**, New York: The Free Press.*

*** Maltreated children are significantly more likely to commit crimes (including sexual crimes) as teenagers or young adults than those with no victimisation history, but the experience of childhood physical abuse may be more closely correlated with the development of sexual aggression in young men than is sexual abuse.*

*It seems it is the exposure to trauma, not sexual abuse per se, that is significant in the emergence of sexually abusive sexuality. Widom, Cathy Spatz (1995) **Victims of Childhood Sexual Abuse – Later Criminal Consequences**, National Institute of Justice Research, Washington. www.ojp.usdoj.gov/nij/pubs-sum/151525.htm*

Slide 15: Time – 11.15



"There is also some evidence that not all offenders who claim to have been abused are telling the truth. A review of assessment interviews conducted over a 20-year period in a sex offender treatment programme in Oregon, USA compared the self-reports of offenders, who were simply interviewed, with those who were interviewed using a polygraph (lie detector).*

As you can see, using a polygraph, the number of abusers who said they were victims reduced by a half, the number who started abusing in adolescence rose dramatically, and the sex of their victims changed from a majority of girl victims to a very close balance of girl and boy victims. It's worth noting that this runs counter to prevalence studies which, you'll remember, indicate a far greater number of girl victims.

The commonly-held belief that victims of abuse are more likely to become offenders can leave survivors very concerned that people who know their history might think they are perpetrators too. If they have children of their own, they can fear that they might become offenders, and some have been put off becoming parents because of this. The misconception is also held by some professionals."

Case example 3:
A survivor's anxiety: *"What will others think about me?"*

Case example 4:
A survivor's anxiety: *"I won't be trusted with my grandchild"*

Case example 5:
A survivor's anxiety: *'Maybe I'll become an abuser"*

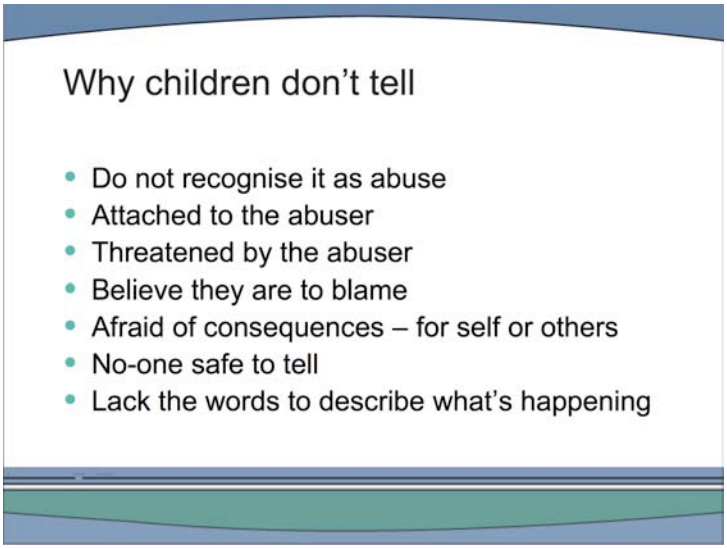
We suggest that you use *either* Case Example No. 3 or 4 *and* No. 5

** Hindman, Jan and Peters, James (Dec 2001) 'Polygraph testing leads to better understanding of adult and juvenile sex offenders' in **Federal Probation** 65, 3. (A summary of this paper is included in the Course Reader.)*

Slide 16

Urge staff who are parents to visit the website to learn how best to protect their own children in their use of the Internet.

Slide 17



Take suggestions from participants before putting up the list, which will appear when you click.

"Many survivors blame themselves for what happened to them as children, or for not stopping the abuse by running away or telling someone what was going on. It can be useful for them to talk about this with someone who can help them understand how powerless children usually are in relation to their abusers.

Why do you think children don't tell? Until they know differently, some children believe that what happens in their family happens to everyone. They may think of the abuse as affection, as punishment or just as part of growing up. There are children who only first realise that they have been abused when they receive sex education, or hear their friends talking about sex at school.

Some adults may continue not to recognise, or name, what has happened to them as abuse, particularly if it was not traumatic, if they experienced it as loving or as something they wanted or sought at the time. They may have been abused by a much-loved father, or by the only person in their lives who provided the affection and attention they needed. Loyalty may keep them silent, as may guilt about their own 'complicity'. They may have enjoyed being 'special' or may have accepted, even demanded, presents or treats in return for not telling.

At the opposite end of the spectrum are children who are silenced by fear. They may believe that the abuser will kill them, their mother or siblings. They may know from their own experience that he is capable of violence. Where there is more than one abuser within the family – it may be both parents, or their stepfather and an uncle/brother for example, or a wider network of abusers – they may believe that escape is impossible. They may have been threatened with going into care, with the family breaking up or the abuser being sent to prison.

The same abuser may use different silencing strategies with different children. Even within the same family, one sibling may be a more vulnerable child and praise and attention will ensure her loyalty, while her brother may be emotionally (and physically) beaten into submission.

Child sexual abusers 'groom' children to be their victims, just as perpetrators of domestic abuse 'groom' their partners into dependency. The victim may be isolated from other people, discouraged from having friends, told how much the abuser loves and needs them and how special they are.

Individual abusers may effectively silence children – but this is made much easier if they operate within a family, community or society where women and children have few rights, or where husbands and fathers are meant to be obeyed without question. Abuse of power is easy in closed communities where children have limited access to outsiders – as has been the case in residential schools and homes and in some religious sects. It can be hard for children to tell, when this would involve telling outsiders who may have negative or racist attitudes towards their culture or religion,

or if they are afraid they would lose their place within their community if they betrayed their abuser.

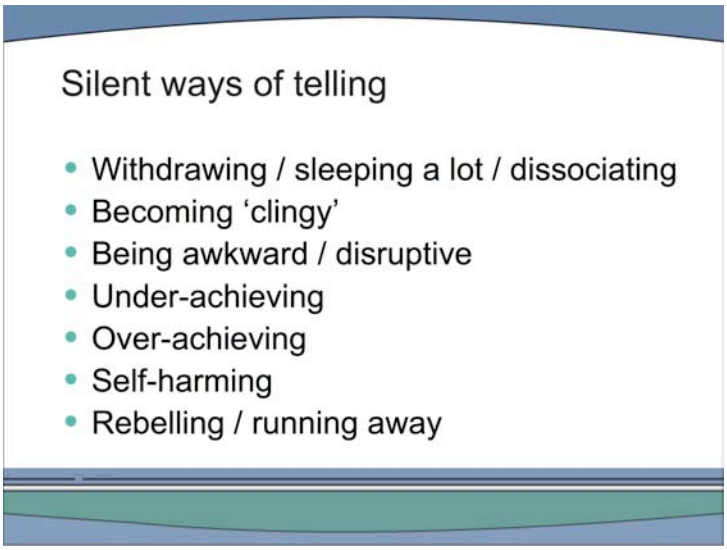
If being taken into care were the outcome of telling a teacher that they were being abused, try to imagine the culture-shock of a residential children's home for a 14-year-old Bangladeshi girl from a strict Muslim family, or for a boy brought up as a Jehovah's Witness.

Children may try to tell but not be able to make themselves understood. Adults may not listen, or too readily dismiss what children say. One little girl told her mum that she didn't like it when grandpa put his "pencil" into her "pocket"; mum took it literally and told her not to be silly. His 'pencil' was his penis and her 'pocket' was her vagina!

Stereotypes and misconceptions may prevent children being heard when they try to tell. Consciously or unconsciously people may believe that 'abuse doesn't happen in respectable families', or in Jewish/Hindu/Christian families, or in expensive private schools, or that it could be perpetrated by anyone they know or are related to."

Case example 6: Illustrates some of the reasons why children don't tell
(Best illustrated on a flip chart; also a change of presentation maintains participants' attention)

Slide 18



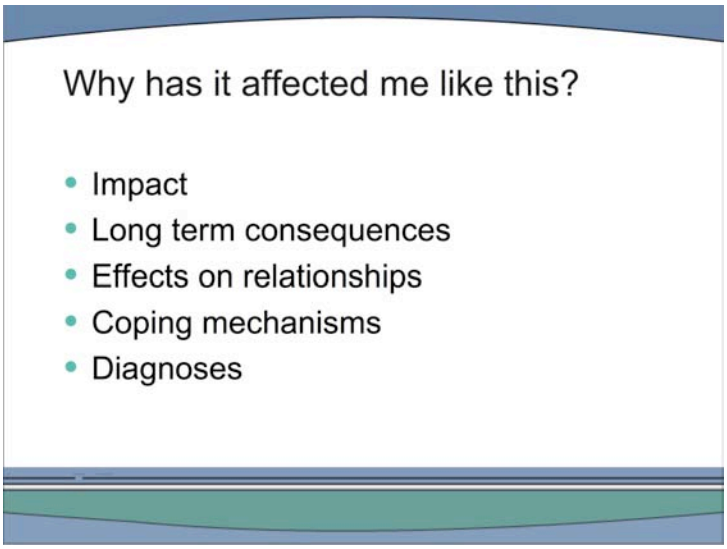
If you prefer, you could ask participants for their suggestions *before* putting up the list, which will appear when you click.

"It can be helpful for survivors who did not 'tell' to understand how their behaviours might have been 'silent cries for help' which nobody paid attention to.

- Those who were abused from a very young age are likely to have developed dissociative ways of coping: 'cutting off', 'forgetting', or thinking of the abuse as happening to someone else.
- They may have clung to their mother in order to try to prevent her from leaving them with an abusive carer.
- They may recall being labelled as 'naughty', 'shy', 'awkward', 'clingy', a day-dreamer or a heavy sleeper.
- Their schoolwork may have dipped because they were unable to concentrate. Alternatively they may have got 'top-marks' because absorbing themselves in school helped them not to think about life at home. They may have focused on achievement because it was the one part of life which they could control.
- Eating disorders and self-harming behaviours can also develop out of the desire for a sense of control, as a distraction from, or way of relieving, distress or as an outward expression of emotional pain.
- These silent ways of telling may meet with unhelpful or even punitive responses. For example, many young men, who 'act out', are externalising their anguish but end up in the criminal justice system rather than receiving the help they need."

This may be a good point to break for lunch (12.30 pm)

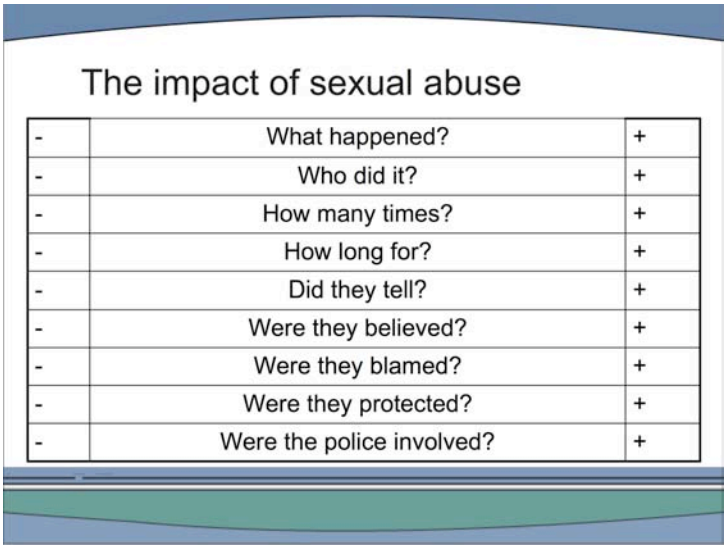
Slide 19: Time – 1.30 pm



"Survivors you work with may struggle to understand the ways in which their abuse has impacted on them, and it can be helpful to discuss the different ways people are affected by abuse, the coping mechanisms they may have developed, and the ways

in which their difficulties have been labelled and treated within mental health services. That is, once we start 'labelling' people, the tendency is to focus on the label and not the person behind that label."

Slide 20



Although a slide has been provided, it is recommended that you draw this on a flip chart (which, if easier, you can prepare in advance). You can then more easily point out – by placing an X on the chart – where, on the continuum of impact, different experiences are likely to either (-) decrease the impact or (+) increase the impact of abuse. Having a break from PowerPoint also helps to maintain the concentration of participants.

- **On the first example, the Xs will all be placed on the left hand side of the diagram near the (-) signs, as all the experiences described are likely to decrease the impact of abuse.**
- **The second example will have an X at the same place in respect of 'what happened' i.e. near the (-) end of the scale, but all other variables will need to be marked with a X near the (+) end of the scale**

To clearly differentiate the difference in impact between the two examples, it is suggested that you use a different coloured pen for the Xs in each case.

"There are many different kinds of abuse. It is sometimes assumed that abuse involving certain sexual acts (particularly involving penetration) will be the most damaging. Of course, what happened and its severity is a key factor, but there are a number of other factors which are likely to increase (+) or decrease (-) the impact of abuse*. A longer duration of abuse has consistently been shown to be associated with more negative outcomes for victims. Research has also shown that repeat

victimisation is not uncommon among sexual abuse victims and that this is, unsurprisingly, associated with more negative outcomes.

For example, imagine that when you were 12 you were flashed at in the park by a stranger, and you went home and told your mum. She believed you and phoned the police. The police believed you and arrested the man who then pleaded guilty. Potentially – little or no long-term effects.

Contrast this with a child who is abused by her stepfather repeatedly over many years. At 14 she tells her mother who accuses her of lying. It may be a similar form of abuse – in that no touch is involved – but it's her father who exposes himself to her, on a very regular basis, masturbating himself whilst she lies in the bath. She eventually tells her mother, who doesn't believe her, doesn't protect her and the police are not involved.

The long-term impact in the first case is likely to be nil, while for the second it could be profound. Many survivors who need to use mental health services have complex family histories and multiple experiences of abuse. They may also have faced disbelief and rejection rather than support. The learning from this exercise is that we should never judge a person's reaction by the *perceived* impact of an abusive experience as *the whole experience* should be understood."

Use one of the following (or one of your own):

Case example 7: Not being believed

Case example 8: Mother not believing (*best illustrated on a flip chart*)

** Finkelhor and Browne (1986) produced an explanatory framework for the differential impact of abuse which consists of four 'traumagenic dynamics': traumatic sexualisation, stigmatisation, betrayal and powerlessness. They consider that much will depend on the child's age and stage of development, and on the amount of force used and fear invoked.*

Subsequent research reviewed by Tyler (2002) bears this out, showing that the severity of the abuse, use of force and the victim's relationship to the perpetrator are especially important.

Stigmatisation refers to all the negative connotations about the abuse that are conveyed to the child and become incorporated into the child's self-image. These may come directly from the abuse, but they can also come from attitudes of peers, family and community. One aspect of this is the experience of 'shame', and Feiring and Taska's (2005) research shows that this may be highly significant.

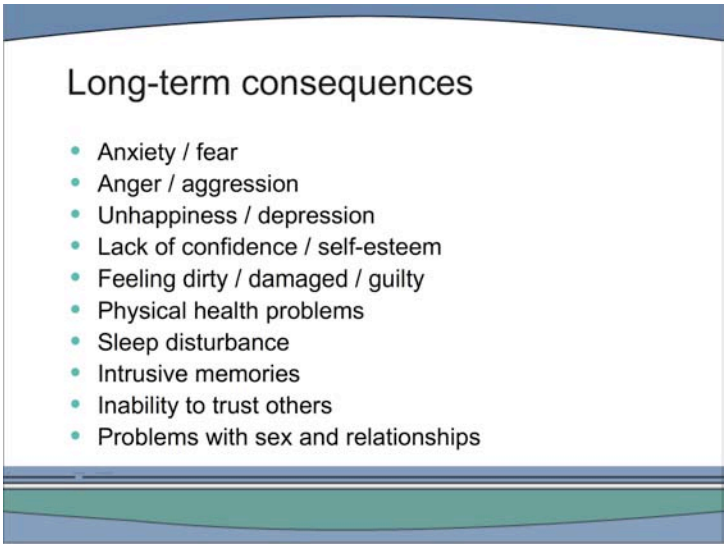
Betrayal refers to the experience of having trusted an adult who has abused that trust, and again, much depends on the nature of the pre-existing relationship with the abuser and on the degree of support from other, non-abusive carers.

References
Tyler, K (2002) 'Social and emotional outcomes of child sexual abuse: A review of recent research' in ***Aggression and Violent Behaviour****, Volume 7, pp. 567-589.*

Feiring, C and Taska, L (2005) 'The persistence of shame following sexual abuse' in ***Child Maltreatment****, Volume 10, Number 4, pp. 337-349.*

Finkelhor, D and Browne, A (1986) 'Initial and long-term effects: A conceptual Framework' in ***A Sourcebook on Child Sexual Abuse****, Newbury Park, CA: Sage, pp. 180-198.*

Slide 21



"There are many common consequences of child sexual abuse. Survivors using mental health services are often those with the most severe ongoing problems, but this is not always the case. As we have just seen, the impact of sexual abuse will vary according to a whole range of factors. However, the long term consequences can be disabling and you will all have worked with people affected in these ways – although you may not have known at the time that they had been abused."

At this point you may want to ask the group how two or three of these consequences can be 'caused by' sexual abuse:

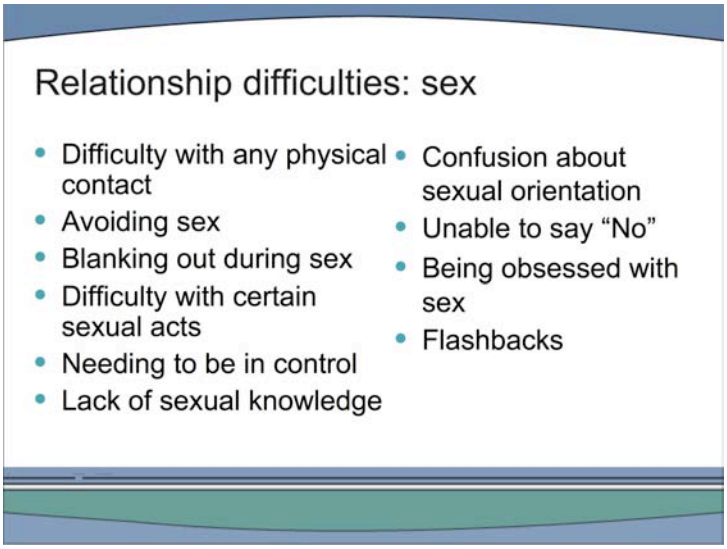
"Why do you think survivors often have difficulty trusting people? Why do you think some survivors feel so dirty?

In providing care for survivors in an in-patient setting, it is important to avoid unwitting re-traumatisation. For example:

- There can be a tendency for staff to disapprove if patients aren't sleeping. However, a survivor may need to stay awake until after the time of night that their abuse used to happen; be fearful of sedation; distressed by staff doing observations at night by entering their rooms or sitting on their beds, particularly if the staff is the same sex as their abuser(s).
- Men survivors can feel particularly fearful on men-only wards.

Mental health services are not always good at recognising physical health needs. Some survivors have physical damage/disabilities resulting from their abuse and may need support to access appropriate services, for gynaecological, genito-urinary or anal continence issues, for example."

Slide 22



You may just want to put up the title for this slide initially and ask the group to suggest what sexual difficulties survivors may experience. Then, expose the bullet points and run through some of the following points, if they have not already been made by the group.

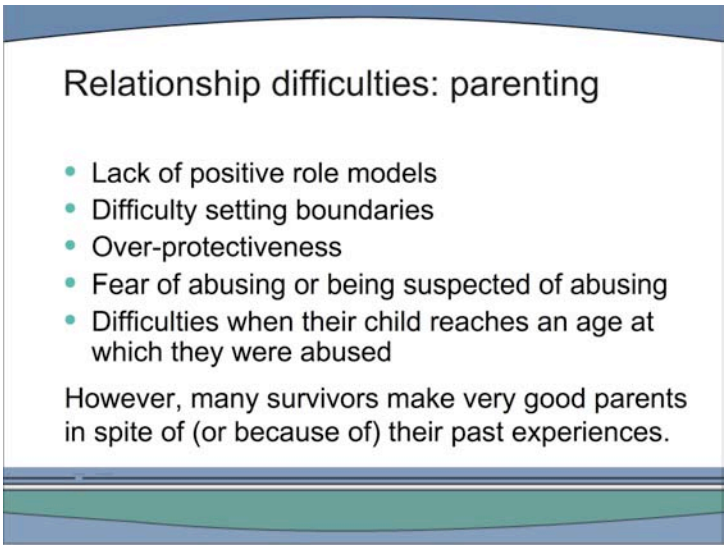
"Survivors sometimes:

- Avoid all physical contact and feel threatened if their personal space is invaded.
- Take part in sexual acts but have to blank out during them e.g. counting patterns in the wallpaper; thinking of other things. Some find ways to dissociate completely so they don't have to 'be there' whilst it's happening.
- Are unable to engage in particular sexual acts that were part of their abuse.
- Are unable to achieve orgasm or have/maintain an erection.
- Only feel comfortable with sex when they are the instigator/are in control.

- Have very limited sexual knowledge, having avoided peer discussions and books or television, or dissociated during sex education.
- Struggle with their own sexual orientation e.g. if they are straight young men who have been sexually abused by men.
- Are unable to say "*No*" or express their needs or rights.
- Confuse sex with affection and be vulnerable to sexual exploitation.
- Have flashbacks of their abuse during sex."

Case example 9: Lack of sexual knowledge – the vagina stretches

Slide 23



"Sexual abuse within the family rarely happens in isolation. It is often associated with domestic abuse, parental alcohol or substance misuse, emotional abuse and neglect. Survivors of extremely abusive childhoods have to learn safe parenting from scratch. Some will repeat some of the patterns they grew up with and, in particular, those who lacked a secure attachment relationship in early life may struggle to establish this bond with their own infants.* However, the majority become very protective parents.

Survivors often struggle not to be over-protective of their children and some are fearful of abusing, or of being suspected of abusing and may even limit their physical contact with a child in reaction to this.

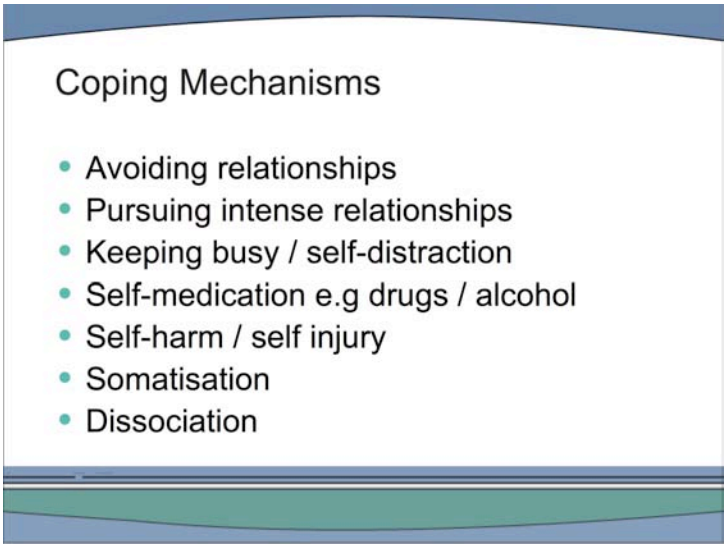
As with other mental health service users, their children and other family members may also be playing a carer role towards the survivor. Consideration needs to be

given to how carers, including young carers, are supported to understand the impact of abuse and ensure their own needs are met.

Survivors, who have repressed or denied their own abuse, may find memories are triggered by, for example, childbirth; their child reaching the age when they were abused themselves; the death of the abuser; the death of a protective parent."

** Cichetti, D and Carlson, V (eds)(1989) 'Intergenerational continuities and discontinuities in serious parenting difficulties' in* ***Child Maltreatment: Theory and Research on the Causes of Child Abuse and Neglect****, Cambridge University Press, pp. 317-348.*

Slide 24



You may want to put up just the title for this slide and ask the group to suggest what coping mechanisms a survivor may have developed in response to their abuse, or its consequences*, before* exposing the list.

"Some coping mechanisms help survivors to avoid memories or thoughts e.g. keeping occupied all the time so there is no time to think, or blanking out when thoughts become too painful. Other mechanisms may be used to dampen down difficult feelings such as rage and shame e.g. abusing drugs and/or alcohol. Some survivors self-harm as a way of releasing painful emotions.

Some survivors somatise their distress and experience it as physical pain. This is particularly common among some cultural groups, including South Asian women.* Some survivors who use mental health services are highly dissociative and may 'space out' and 'lose time' to avoid distress, or become so 'taken over' by memories

and emotions that a dissociative state is sometimes interpreted as a psychotic episode."**

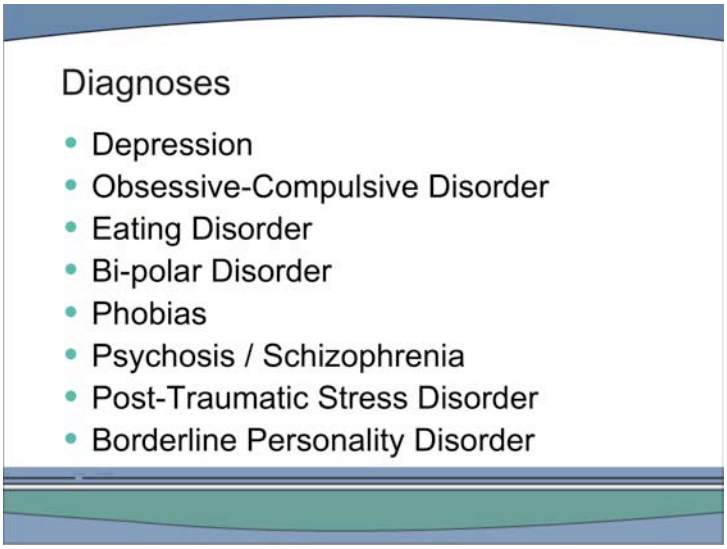
You need to check that everyone in the group understands the term 'dissociation'.

Case example 10: Coping mechanisms – dissociation

** Hussain, Feryad and Cochrane, Ray (2004) 'Depression in South Asian Women Living in the UK: A Review of the Literature with Implications for Service Provision' in **Transcultural Psychiatry**, Vol. 41, No. 2, pp. 253-270.*

*** Mollen, Phil (1996) **Multiple Selves, Multiple Voices: Working with trauma, violation and dissociation**, Chichester: Wiley.*

Slide 25



"All these diagnoses are frequently attached to survivors of child sexual abuse. Each is descriptive of a set of symptoms or difficulties which they experience – difficulties which often stem directly from their abuse or the coping strategies they developed to survive it.

Diagnoses address the question: *'What is wrong with this person?'* rather than *'What has happened to this person?'* We cannot go into details about each diagnosis today, but some case examples of survivors who have attracted a couple of these diagnoses may be useful.

- OCD:

  One survivor who was diagnosed with OCD had for many years washed all the family's dirty clothes every night, including sending her husband to bed naked.

She also used diluted bleach, brushed lightly over her carpet, before she could go to bed – yet still held down a full time job and raised her child. Her husband finally said "*Enough's enough*" when she started hoovering the mortar in the outside brickwork.

- Eating disorders:

A survivor with a diagnosis of bulimia had been working at a petrol station and had been eating a box of crisps a day, as the crunching sound helped to block voices in her head.

- Phobias:

Survivors can be left with a wide range of phobias directly or indirectly associated with their abuse e.g. fear of small places, the dark, particular objects etc.

Case example 11: A fear of police officers

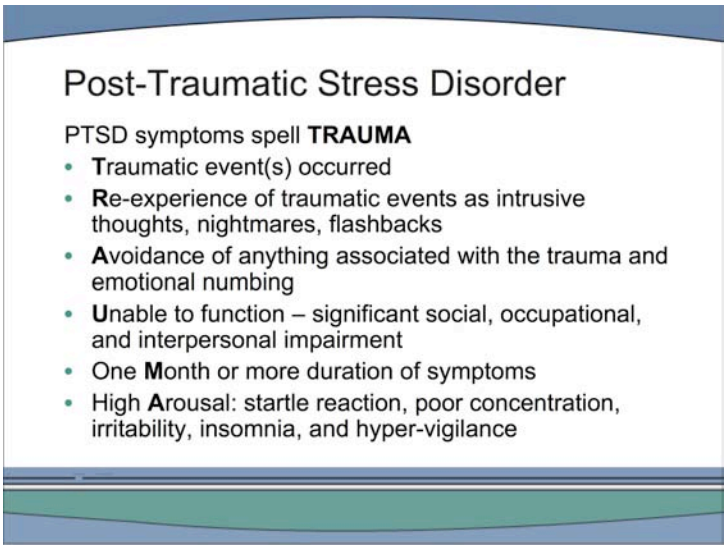
- Psychosis:

There is a growing amount of evidence that child sexual and physical abuse is related to the symptoms of psychosis and schizophrenia. For example, a study of over 4,000 people in the Netherlands found that those who had suffered severe child abuse were 48 times more likely to have 'pathology level psychosis' than people who had not been abused as children.*

** Janssen, I, Krabbendam,L, Bak, M et al (2004) 'Childhood abuse as a risk factor for psychotic experiences' in* ***Acta Psychiatrica Scandinavica****, 109, pp. 38-45.*

For participants who want further information on the possible relationship between psychosis and abuse, refer them to the reference list at the end of the Read, Hammersley & Rudegeair, 2007 article in their packs.

Slide 26



"PTSD is extremely common among survivors of sexual abuse but it is often not diagnosed as the patient has to first tell us about the trauma* before a PTSD diagnosis can be made. Studies have shown that child sexual abuse is associated with PTSD in adults and that the severity of PTSD symptoms is associated with the extent of the abuse.** Similarly, studies of sexually abused children have shown a link with PTSD.***

Adults who develop PTSD in the aftermath of a public disaster or crime in developed countries are more likely to be offered de-briefing/counselling. Many who suffer PTSD as a consequence of involvement in armed conflict or domestic abuse will suffer without external help or acknowledgement.

You may remember the case of the man who formed the human bridge in the Zebrugge ferry disaster. He was hailed as a hero on national TV, in the news, in interviews etc… nine months later he suffered chronic PTSD. The symptoms in such a case might well include fear of water, the avoidance of boats and swimming pools and flashbacks triggered by media coverage of the disaster. It wouldn't be difficult to explain this to friends and colleagues. Imagine how much harder it would be for a survivor of abuse to tell their partner that they are having flashbacks during sex.

PTSD symptoms can occur many years after the event."****

Case example 12: Traumatic memories in her 80s

** This is the American Psychiatric Association's mnemonic for the symptoms of PTSD. Khouzam, H R (June 2001) ' A simple mnemonic for the diagnostic criteria for post-traumatic stress disorder' in* ***Western Journal of Medicine****, 174(6), p. 424.*

*** Briggs, L P and Joyce, L (1997) 'What determines post-traumatic stress disorder symptomatology for survivors of childhood sexual abuse?' in **Child Abuse and Neglect**, 1997, Volume 21, Issue 6, pp. 575-582.*

**** M Runyon and M Kenny, **Child Maltreatment**, 2002, Volume 7, Issue 3, pp. 254-264.*

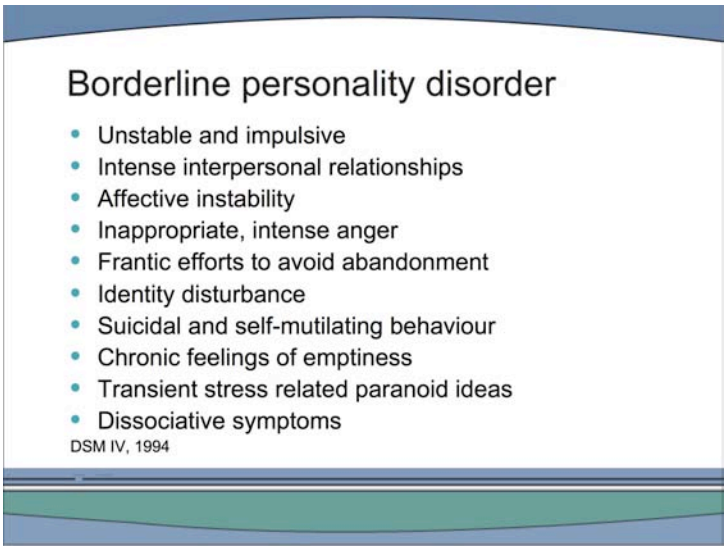
***** NICE guidelines for the management of PTSD are available at* www.nice.org.uk/CG26 *The guidelines recommend that CBT or EMDR are appropriate interventions for PTSD.*

The following U.S. links provide useful information on developing trauma-informed services:

http://womenandchildren.treatment.org/media/presentations/c-1/Harris.ppt

www.nationaltraumaconsortium.org

Slide 27



"Survivors of sexual abuse in the mental health system often attract a BPD diagnosis. You can see that many of the traits listed reflect the long term consequences and coping strategies we have been discussing.*

However, unlike PTSD, the BPD diagnosis makes no reference to the likely origins of such traits. Until very recently, personality disorders have been 'diagnoses of exclusion' and have been seen as 'untreatable'.** Survivors often find a BPD diagnosis stigmatising and unhelpful; some clinicians consider that the term 'complex PTSD' is more appropriate."

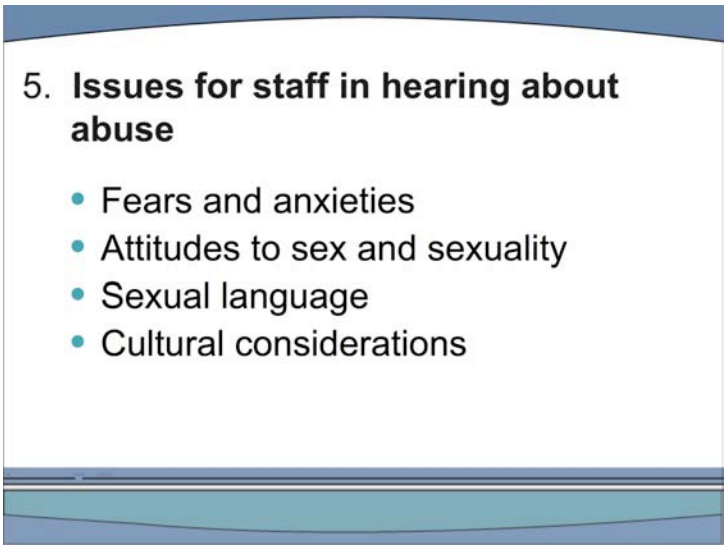
** For a particularly insightful analysis of how abuse in childhood can shape the ways in which adults form relationships see: Herman, Judith (1992)* ***Trauma and Recovery,*** *London: Pandora, p.111.*

*** Personality Disorder: No Longer a Diagnosis of Exclusion: Implementation Guidance, Department of Health, 2003.*

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009546

Section 5. Issues for staff in hearing about abuse

Slide 28: Time – 2.10 pm



Exercise: In two groups of up to eight people (split into four if your group is larger than this) with a flip chart each. Allow 10 minutes.

Group 1:
A survivor of abuse has decided they wish to disclose to their key worker. Take 10 minutes to write on the flipchart what feelings they may be having just before making the disclosure.

Group 2:
You as practitioners are hearing a disclosure of abuse. Take 10 minutes to write on the flipchart what you might be feeling as the disclosure occurs.

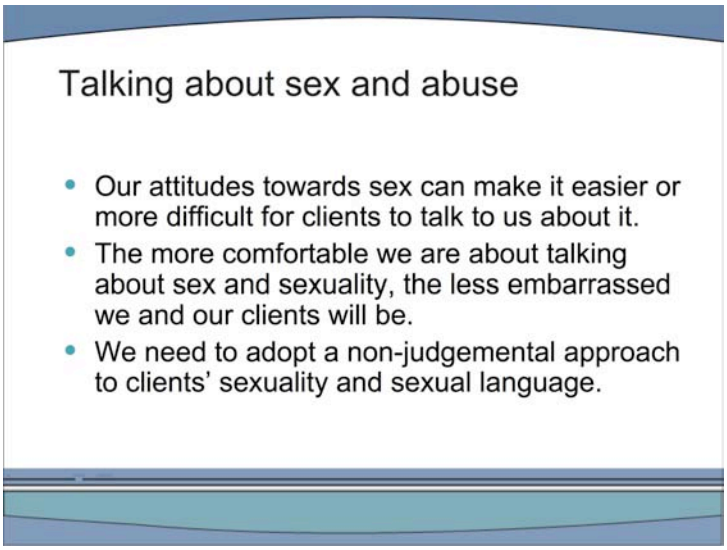
Take brief feedback from the two groups: acknowledge the anxieties as normal, without getting bogged down in them. In relation to cultural considerations, point them to the extracts in their Course Reader from *Crossing the Boundary: Black women survive incest by* Melba Wilson, Virago Press, 1993.

This exercise has three purposes:

1. **It allows staff to ventilate their anxieties about hearing a disclosure.**
2. **It encourages them to empathise more directly with the feelings of a survivor about to disclose.**
3. **It highlights the similarities of feelings on both sides.**

The next slide begins to focus specifically on disclosure.

Slide 29: Time – 2.30 pm



"Most of the conversations survivors need to have about their abuse will have no sexual content. Details of the abuse are rarely dwelt upon. However, there may be times when a survivor needs to tell you about something specific that happened to them, or refer to a current sexual problem. When this happens you need to be able to hear what they have to say and not let your own attitudes or embarrassment get in the way.

Practitioners need to be comfortable hearing survivors speak of their experiences in whatever words they choose to use. Survivors are likely to be hyper-vigilant or extremely sensitive to staff discomfort, and may therefore be deterred from disclosing.

Staff, like service users, come from a wide variety of cultural and religious backgrounds where it may very well *not* be 'the norm' to talk openly about sexual matters, or where they hold strong views about issues such as sex outside marriage or homosexuality. Staff need to find ways of putting aside personal feelings and views in order to respond non-judgementally to survivors.

There are a huge number of slang terms associated with sexual activities. This is a light-hearted exercise to see how many you know."

Group exercise:

You can either go round the room asking each person to give a word for penis, then go round again with each person giving a word for vagina; or the exercise can be done in three groups with one group jotting down all the words they know for penis, one for vagina and one for sexual intercourse.

You need to make a judgement about how appropriate this exercise is for your particular group. It can work very well but, where you have staff from very different cultural and religious backgrounds, it can be experienced as alienating.

The point you do need to make, however, is that all staff need to be able to listen and respond appropriately to disclosures however they are expressed.

"Using language that service users understand and feel comfortable with is part of providing an accessible and sensitive service. It is also important to hear what is actually said and not make assumptions.

What do you think a client meant when she said "*He made me go down on him*"?
The client in question was actually referring to having to lower herself onto her abuser's penis so that she was sitting on top of him – and not to oral sex as most would think.

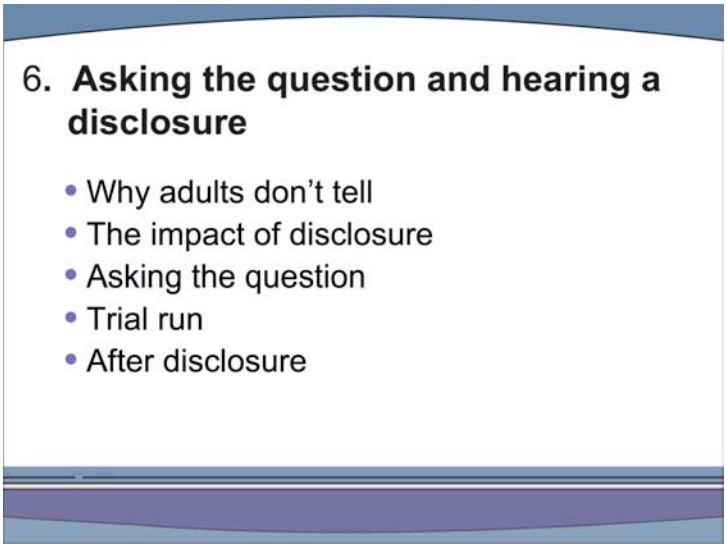
Imagine if a worker's misinterpretation had been written down. This could have a serious impact on the outcome of a case that went to court – if the client claimed that sexual intercourse had taken place and the practitioner's notes had said that she was forced to have oral sex with him."

Case example 13: *"Oh, you mean my cunt?"*

This might be a good point for the mid-afternoon break (2.45 pm)

Section 6. Asking the question and hearing a disclosure

Slide 30: Time – 3.00 pm



"In this next section of the course we are going to focus specifically on asking the question and hearing a disclosure. We have already talked about why children suffering abuse feel unable to tell anyone. Difficulties in telling can persist into adulthood.

As we have noted, many users of mental health services are survivors of abuse but may never have disclosed this to professionals or, in fact, to anybody. It is important to have some understanding of why adults don't tell in preparation for asking a direct question about abuse."

Slide 31

"Many services users who have experienced sexual abuse will carry the fear of telling from childhood into adulthood. They may often have been told by the offender that they wouldn't be believed. This fear of being disbelieved is very real – it often happens – especially when a service user has already gained a reputation for being 'unreliable'.

Case example 7: Not being believed

Case example 8: Mother not believing *(best illustrated on a flip chart)*

Sometimes the beliefs about the consequences of telling are irrational but very powerful and real to the survivor.

Case example 14: Lovely curly auburn hair

Disbelief is not the only negative response that survivors fear, and indeed, experience. Black and minority ethnic survivors may fear that a disclosure will reinforce racist stereotypes. Some professionals may be tempted to minimise the experience with responses such as "*That was a long time ago, you need to put it behind you".*

For family and friends, reality can be hard to accept. For example, a mother may have difficulty hearing that her partner or ex-partner sexually abused her daughter; older siblings, if they weren't abused themselves, *can't believe that their dad would do that.* Even if they also suffered abuse, they may not welcome it coming out.

Case example 15: Shock response

The beliefs held in childhood that the abuse happened because "*I was bad"*, because "*I was pretty",* because *"I asked for it"*, because "*I didn't make it stop",* can if left unchallenged continue intact into adulthood. Survivors can therefore feel intense shame about the abuse and wish to keep it hidden from others.

People can repress memories to varying degrees:

- For some, the memories are constantly present with the survivor struggling to push them out of their mind.
- For others, they can be at the back of the mind occasionally flicking to the forefront.
- And others may have repressed the memories so completely that they only emerge when triggered by a significant event in later life, perhaps when the survivor has a child of their own, or when their child reaches the age they were themselves when the abuse started etc.

You can't assume that the offender – or offenders – is no longer present in the survivor's life. If their abuser is a family member or part of the survivor's community, then they may well still have considerable power. A victim might by this stage even be the carer of their abuser. In other instances, their abuser may also be their 'carer' – this may well be the case for service users who have learning difficulties. Even as adults, victims often still live in fear of threats made by the abuser.

Worries about the impact of disclosure on families can be very powerful. It is not unusual for survivors to believe that "*Mum would die if she knew"* or *"My family would disown me".*

Some people belong to very close-knit communities with their entire personal, family and social life being interconnected. Examples include some rural communities, those attached to a particular religious group and some communities united by culture or language."

Include the following case examples unless you are able to replace them with equivalent ones from your own practice experience.

Case example 16: A homeless Asian woman

Case example 17: Disclosure by a Deaf survivor

"In such circumstances, the fear of not being believed may be far greater and the potential consequences of disclosure more life-shattering: a survivor is risking the loss of *all* their support. They may also fear encountering a lack of understanding and racist assumptions from professionals they disclose to."

Slide 32

"As we have already noted, many survivors of sexual abuse who come to use mental health services have had compounding difficulties in their histories. Not

uncommonly this will have included emotional abuse and family conflict. They are less likely to have had reliable care and support from a non-abusing parent. Some service users may already have had experience of making disclosures which have had negative consequences for them or for those they care about."

You may wish to illustrate with one of the following:

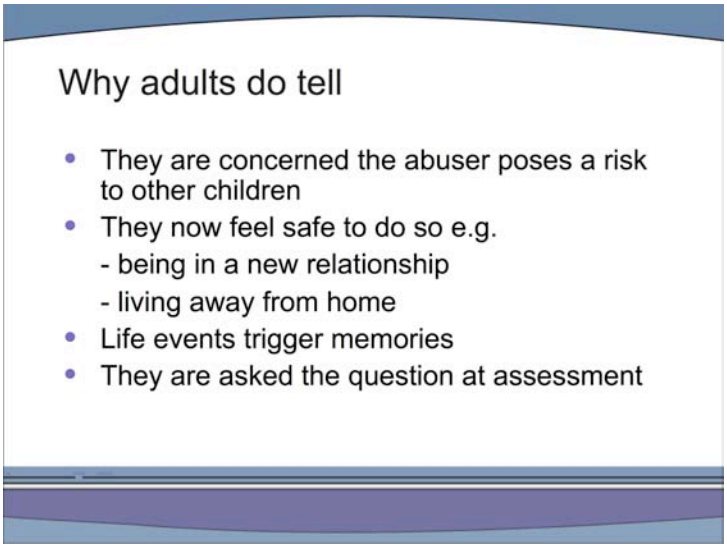
Case example 8: Mother not believing *(best illustrated on a flip chart)*

Case example 18: Mother not protecting *(best illustrated on a flip chart)*

"As this case illustrates, once a disclosure has been made, family members are forced to take sides – there is no sitting on the fence when it comes to believing or not believing that abuse occurred. But don't forget that lots of mothers do believe and support their children, who are then less likely to need mental health services in the future.

The impact on the family as a whole, and on individuals within it, can be devastating. It is therefore important that survivors have time and support to think about the possible consequences of disclosing to their family or of going public e.g. reporting to the police. The advantage of talking to a professional is that – provided there are no details disclosed which would trigger immediate safeguarding procedures – a survivor can work through their hopes and fears in relation to breaking the silence about their abuse, and be better prepared for some of the fall-out that can occur."

Slide 33



"Some survivors will choose to disclose because they wish to protect other children. In these circumstances, a service user may immediately want to provide you with information you can pass on to the relevant social services department. Others may

never have considered that their abuser would abuse anyone else, and only begin to think about this as they talk through their own abuse.

Some survivors choose to talk about their experiences at a point in their lives when they feel safe to do so. Others feel rather less in control of the disclosure because they are overwhelmed by memories and the feelings they bring with them. As we have already mentioned, life events may trigger memories. Less personal triggers can include TV programmes or encountering sexual abuse through work or friends.

However, the triggering of memories does not necessarily lead to telling someone immediately – nor does being asked the question at assessment. Some survivors so much fear that they will be 'labelled mad and locked up', or have their children taken away from them, that they hide flashbacks and panic attacks, self-harm and phobias for years. Others simply decide to disclose at a later date when they've thought more about it, or have had a chance to decide who they feel most comfortable telling.

We do know that providing opportunities for survivors to speak about their abuse will increase the numbers who choose to disclose at some point, although not necessarily at the assessment stage when first asked the question.

However, we may need to accept that, for some service users, mental health services do not represent a safe context for disclosure, particularly if they belong to groups which historically have met with less than perfect understanding. This includes lesbian, gay and trans-gender service users, as well as those from Black and minority ethnic communities*.

It is the responsibility of all of us to change this situation by educating ourselves about the issues for different service users and making mental health services safe, accepting and respectful for all who need them."

** Gupta, Rahila (ed) (2003)* ***From Homebreakers to Jailbreakers****, Southall Black Sisters, Zed Press. This book sets out to map that terrain where race and gender make competing claims. It covers a range of issues, ranging from forced marriage to religious fundamentalism www.southallblacksisters.org.uk*

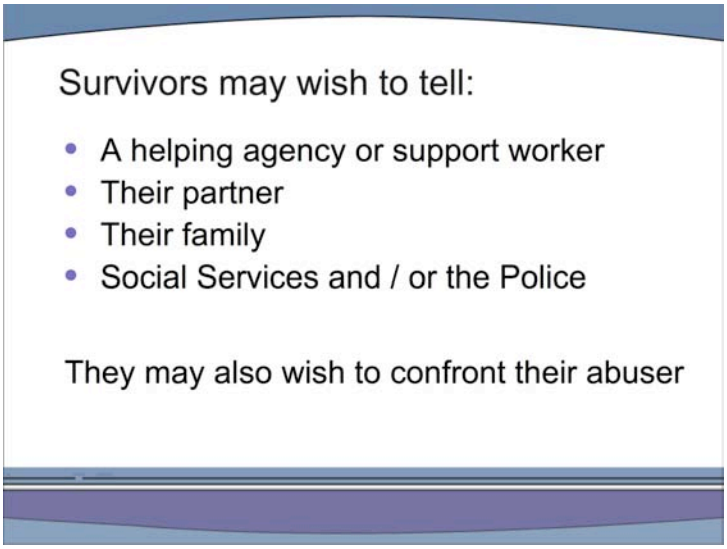
Wilson, Melba (1993) ***Crossing the Boundary: Black Women Survive Incest****, Virago Press. Discusses the plight of Black women in Britain who have had to deal with incest, and shows how the pressure to preserve the family and the myths about Black women have hindered the healing process.*

Since the 1980s, Survivors UK has been providing information, support and counselling for men who have been raped or sexually abused. They run a National Helpline: 0845 122 1201 (7 pm-10 pm Mon/Tue/Thu) www.survivorsuk.org

Harper, Mike Lew (2004) ***Victims No Longer): The Classic Guide for Men Recovering from Sexual Child Abuse*** *(Second Edition).*

Rafanello, Donna (2004) ***Can't Touch My Soul: A Guide for Lesbian Survivors of Child Sexual Abuse****, Alyson Publications Inc.*

Slide 34



"Survivors who are newly disclosing often choose to talk, first, to someone in complete confidence. Local and national helplines run by voluntary agencies are therefore popular. Some will go on to seek face-to-face support by seeing a rape crisis counsellor or joining a survivors' group in the voluntary sector. Others, who are using mental health services, may choose to tell their key worker. The professional's response to a disclosure needs to be accepting, respectful and supportive – but staff do not need to have all the answers.

Some survivors will need support in disclosing to a partner or their family, if that is what they want to do. Staff should help them to prepare for the possible consequences/reactions following disclosure. A few voluntary agencies run support groups for partners or will offer one-to-one support.

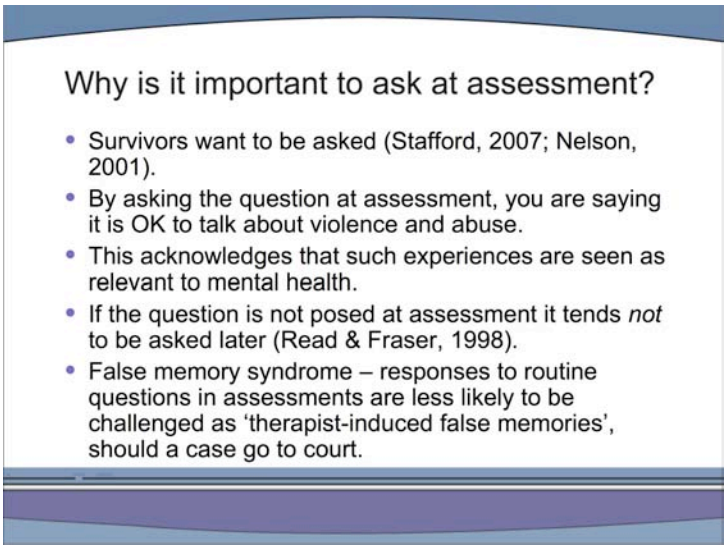
Raising safeguarding concerns, about children an abuser may still have contact with, can be done without the survivor having to make a police statement about their own abuse. The fact that they have a choice needs to be clear to them.

A practitioner can contact Social Services on the survivor's behalf. If they wish to report their own abuse to the police, first contact can be made by the practitioner, who can arrange a time and place for an interview that is comfortable for the client, and accompany them if they so wish. Where any official report is considered, the survivor should be kept fully informed.

If staff aren't clear on how to proceed, they should seek advice from the Trust's Safeguarding Lead; we will come back to this.

Some survivors want to confront their abuser either in person or by letter. They may hope that the abuser will acknowledge and take responsibility for the harm they did. As this is often not the case, staff can help survivors consider the less desirable responses they may meet, including silence, denial and dismissal. Some survivors benefit from writing their abuser a letter and then destroying rather than sending it."

Slide 35



"The evidence is that survivors want to be asked about their experience of violence and abuse.* Asking at assessment gives service users the message that the significance of violence and abuse to people's mental health is recognised, and that the assessor is equipped to discuss such experiences if they wish. Not asking reinforces the message that many survivors will have heard from their abuser; that this is something not to be spoken about – so shameful that even mental health services avoid it.

It is important to ask at assessment as there is evidence that, if the question is not asked at initial assessment, it won't get asked later.** Of course, there will always be occasions where it is not possible to ask at an initial assessment. Where this is the case, the reason should be clearly recorded and the professional conducting the assessment needs to take responsibility for following up when the client is less distressed. Practitioners – who have in the past waited until rapport was established, before asking about experiences of abuse – should consider that for many survivors, asking may be a crucial act that encourages rapport, rather than being a barrier to it.

However, the question should not be asked in isolation. Asking routinely in the course of an initial assessment protects mental health professionals from accusations

of having 'asked leading questions', 'planted the idea in his head' or 'encouraged a client to construct false memories'. Where a therapeutic relationship has already been established, this may sometimes occur because some clients may need and want to please a practitioner – as well as find an explanation for their own distress.

Case example 19: False memory pitfall for nurse

The accusation that a survivor is suffering from 'False Memory Syndrome' – induced through therapy, reading self-help books or attending a survivors' group – may become a feature of the defence case for alleged abusers in cases of historic abuse. There is an active False Memory Syndrome Association which supports people – particularly parents – who are accused of sexual abuse and often provides expert witnesses in court cases.***

Good practice in terms of:

- only asking the question within an assessment and *not* as an isolated question, coupled with
- recording the content of a disclosure clearly – in the survivor's own language or with clarification of detail

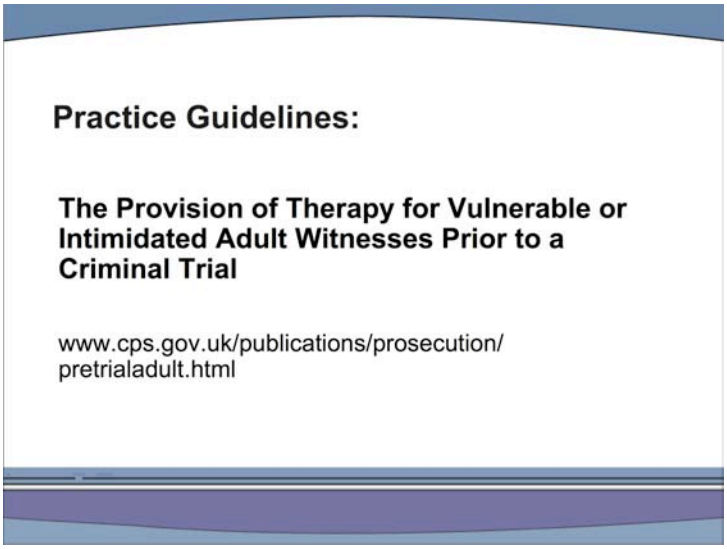
is protective of both client and professional, should a case go to court."

** Stafford, Penny (2007)* ***Service user consultation report****, Walkerhill Consultancy; Nelson, Sarah (2001)* ***Beyond Trauma: mental health care needs of women who survived child sexual abuse****, Edinburgh: Health in Mind.*

*** A New Zealand study compared rates of disclosure when patients were asked about past trauma on admission or not. If asked on admission, 47% disclosed sexual abuse; if not asked, only 6% later disclosed either spontaneously or in answer to a later question. Read, J and Fraser, A (1998) 'Abuse histories of psychiatric in-patients: To ask or not to ask?' in* ***Psychiatric Services*** *49, pp. 355-359.*

**** You can access information produced by the British False Memory Syndrome Association at www.bfms.org.uk For critical perspectives on the concept of FMS in relation to survivors of child abuse, see Mollon, Phil (2000)* ***Freud and False Memory Syndrome****, Icon Books, or Scott, Sara (2001)* ***The Politics and Experience of Ritual Abuse****, Open University Press, Chapter 2. Or visit websites such as www.rememberingdangerously.com*

Slide 36



"These guidelines advise on the conduct of therapy if a prosecution is going forward. They suggest that clients should not be encouraged to discuss the evidence in therapy prior to the trial. They suggest the avoidance of certain kinds of therapy including hypnotherapy, psychodrama, regression techniques and unstructured groups. They were produced in response to the recognition that witnesses, including vulnerable or intimidated adult witnesses, had been denied therapy pending the outcome of a criminal trial, for fear that their evidence could be tainted and the prosecution lost. This had been occurring in reaction to challenges to the validity of recovered memories in cases of historical abuse.

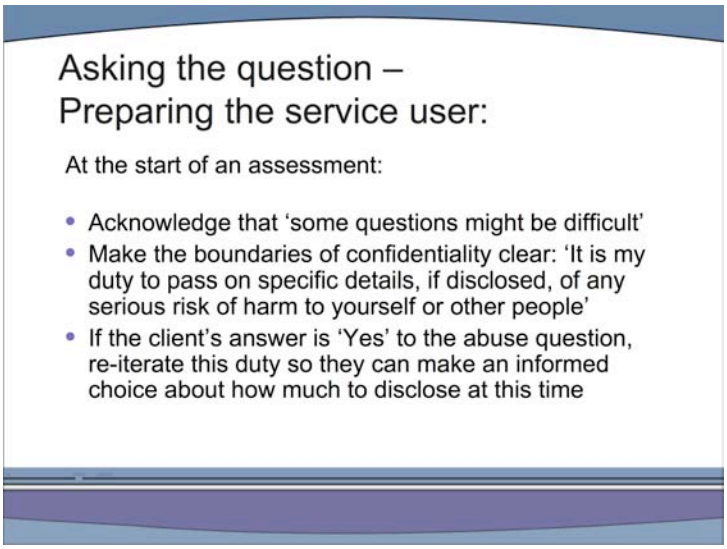
The guidelines are intended to ensure that survivors can still access therapy, but of a kind which avoids any accusations that their memories are being 'contaminated' or 'therapist-induced'. They should be accessed by anyone who is supporting a client during their – often traumatic – journey through the criminal justice system. They are available on the Crown Prosecution Service website, and an example of a trust policy flowing from these guidelines (South Staffs & Shropshire) is in your Course Reader."

Take a copy of the guidelines along in case anyone wants to see them.

"Where a report is made, and an investigation or prosecution results, it is important that mental health services and individual professionals do not feel pressurised into handing over a patient's case notes. Even if the patient has signed an authority for the police to have their notes, it still might not be in their best interest. Staff should always take advice before doing so.

Any survivor who is involved in a criminal trial is likely to require support from their key worker or other staff at every step, as it can be an extremely traumatic experience."

Slide 37



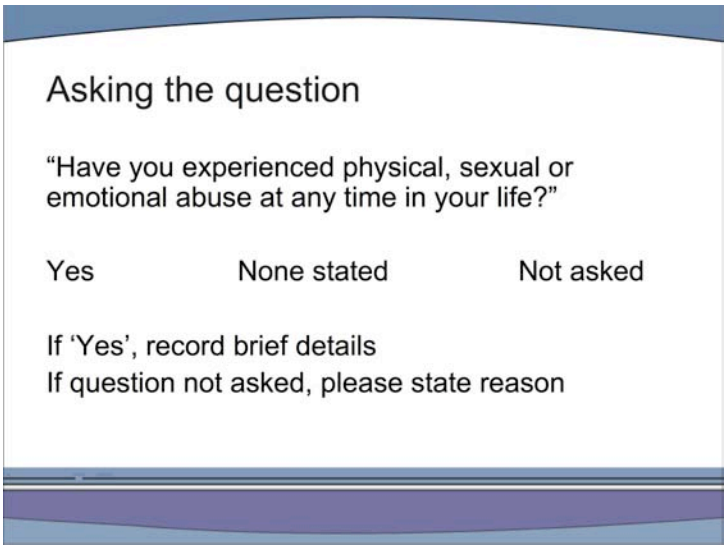
"It is always good practice to prepare the service user for the difficult questions which an assessment involves. It is also good practice to inform service users of the limits to confidentiality at the outset. Make it clear that if, and only if, you are given specific details relating to a 'risk of significant harm' (such as names and whereabouts of an abuser in contact with children), you are obliged to pass these on. Clients will then be clear about what they can disclose.

It is important that the survivor feels a sense of control in the process, and you avoid the possibility that a survivor 'discloses all', but then regrets giving details that require staff to breach their confidentiality. In the majority of cases, in order to protect others who might be at risk, survivors will give details at a point when they are better prepared for the consequences.

Although it is not encouraged for service users to be accompanied during an assessment, this is sometimes the case and their partner or a parent may be present. In most circumstances, all questions should still be asked including the question about any experiences of violence and abuse. The service user may not choose to answer it then and there, but they will be aware that it's something that is routinely asked, and may therefore feel more able to disclose subsequently.

If, as a practitioner, you strongly suspect that you are conducting an assessment in the presence of an abuser, this is likely to compromise the validity of the assessment and you are advised to defer asking the question (and any other questions relating to family history/relationships) until you are in a more appropriate context."

Slide 38



"This is the question as it should appear in your assessment documentation.

There should also be a space for you to record brief details of any disclosure and, if the question was not asked, any reasons for this (e.g. carer/partner present during the assessment). The reason it is important to record 'None stated' rather than 'No', is because a service user may not choose to disclose at this time but may do so later. If it ever came to court, an initial 'No' response in their records could be used to challenge the veracity of their claim. The question is also formatted like this so that it can be audited easily."

At this point, trainers should briefly clarify with participants where the question appears in their documentation, and highlight any plans to audit routine enquiry.

"The aim is to keep the question simple and direct. It should be asked without preamble in exactly the same way, and in the same tone of voice, as all other questions within the assessment process. The evaluation of the pilot stage of the initiative provided lots of evidence that staff often believe they are asking about violence and abuse, but are actually doing so in such an indirect way that they are unlikely to elicit much response. Tentativeness, on the part of a professional, suggests they are nervous of the subject and don't really want to know. One consultant genuinely thought that she was asking the question – because at the end of every assessment she would say to her clients *"Is there anything else you want to tell me?"* This is not asking the question!

Staff sometimes ask *"If the patient is psychotic, would you still ask the question?"* Of course there are situations when a service user is too disturbed or distressed for an in-depth assessment to be undertaken; where a patient is admitted to hospital, an assessment may take place over several days. However, it should be borne in mind

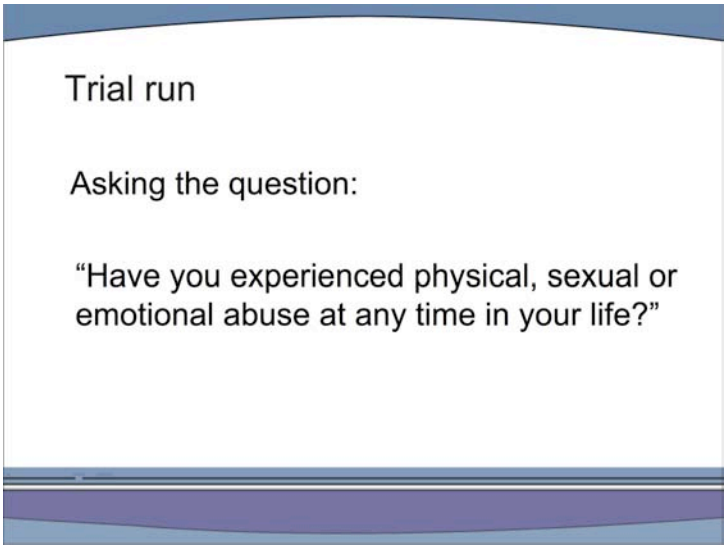
that some dissociative states and prolonged flashbacks can be mistaken for a psychotic episode, and that there is increasing evidence that child sexual and physical abuse can be related to the symptoms of psychosis.*

There may be personal reasons why a particular member of staff does not feel able to work in-depth with issues of sexual abuse at a particular time. They may be a survivor themselves, or be supporting a friend or family member with issues of abuse. All staff are required to ask the question in assessments but can then refer to a colleague to follow up if a disclosure takes place. This is no different to a practitioner, who has recently been bereaved, passing on a case involving bereavement issues.

If English is not a service user's first language, it is the trust's mandatory obligation to provide an independent translator – not a member of their family or family friend, even if the service user seems happy with this. Wherever possible, the translators used should be familiar with the sensitive questions asked in mental health assessments and comfortable in translating this particular question. They should also be provided with support e.g. in instances where they translate service user experiences that they may find distressing. All translators are required to sign a confidentiality clause."

** Read, J , Hammersley, P and Rudegeair, T (2007) 'Why, when and how to ask about childhood abuse' in* ***Advances in Psychiatric Treatment****, 13, pp. 101-110.*

Slide 39



Paired exercise:

Allow no more than 10 minutes in total for this exercise. It works best without too much introduction. Divide the group into pairs: one is the practitioner, who asks

the question, the other is the service user who says "*Yes*". (An alternative is to divide the group into threes with one person acting as an observer to the pair.) Instruct the group as follows:

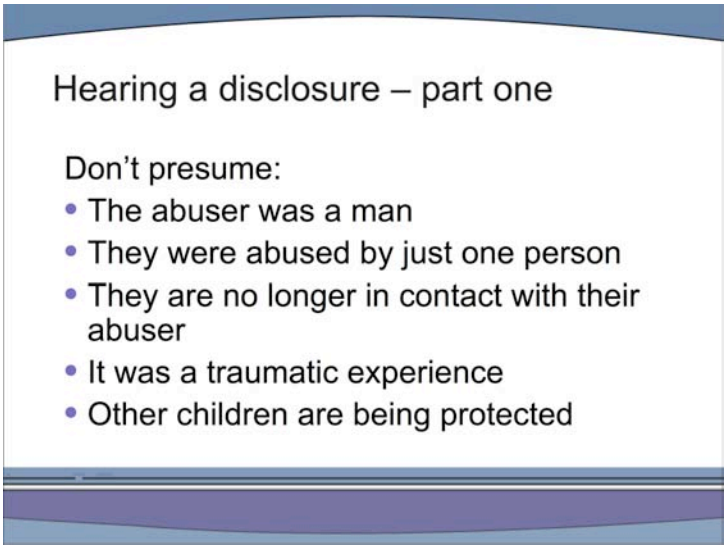
"This is just to give you a quick trial run of asking the question in the way I've described. Let's assume you are undertaking the family history section of an assessment and the question you have asked immediately beforehand is: *"Tell me about your family make-up, your parents, brothers and sisters?"*

The practitioner should ask the question, listen to the answer and then ask a couple of follow-up questions. These shouldn't be too probing; you are just letting the service user know that you have heard them and that this is an OK topic for them to talk about with you. You have just three minutes and then I'll ask you to swap roles."

After the trial run

"You may like to tell your partner how that was for you… Does anyone have any comments or observations they'd like to share with the group?"

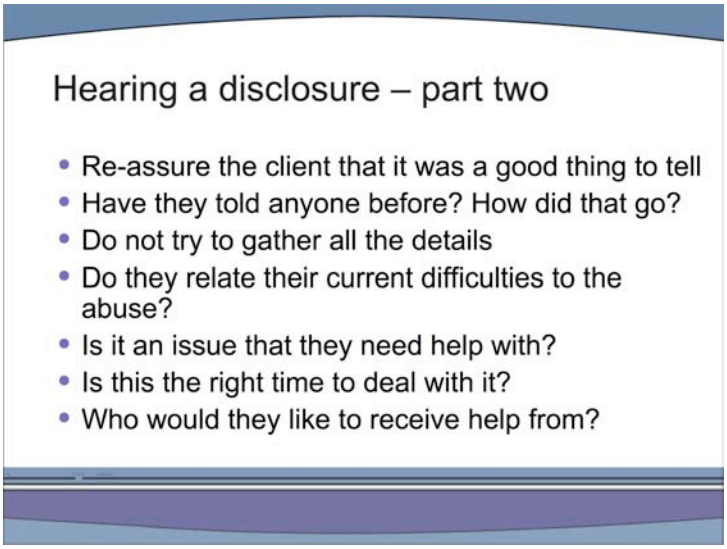
Slide 40



"If a wrong assumption is made by the professional at the outset, the client may struggle to say – *"No, it wasn't like that".* It is therefore important not to presume that what they have to tell you will fit a stereotype of child sexual abuse. They may have been abused by a woman, or by more than one person. As a child, they may have enjoyed the treats, attention or affection, or they may have experienced sexual pleasure during the abuse. Their abuser, or abusers, may still be involved in their lives; they may be doing the dutiful family thing and still having Sunday dinner with them.

Many will presume that they were the only victim and will not have considered that others may be at risk. They may be adamant that no-one else has been abused by their perpetrator, only to find out later that their own child, or their siblings, have also been his victims. We'll come back to safeguarding children and your responsibilities as a professional shortly."

Slide 41



"The key points here are:

- Don't assume, because someone has told you they were abused, that they will immediately require further help. They might have dealt with the abuse previously or already be getting help elsewhere. Asking whether they have told previously should clarify whether this is a first disclosure, a resolved issue for them or something in between.

- Few survivors will want to go into much detail at an initial assessment and this should be respected. Be clear that there will be further opportunities for them to talk about their abuse if they want to, either with you or someone else (and make sure that there is).

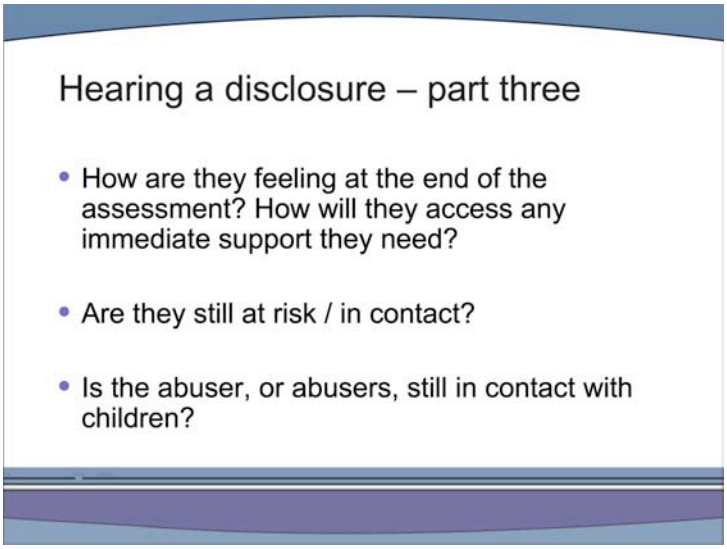
- It's important to find out whether the service user thinks the abuse is a causal factor in their mental health difficulties. You are thereby treating the client as an expert on their own lives. You may not agree with their view – but this is probably not the best time to discuss that.

- It is also useful for the client to assess how problematic or intrusive difficulties relating to their abuse are for them. Someone who gets the occasional flashback may not want to open their personal can of worms. Abuse should be a problem for them before we try to fix it.

- Sometimes survivors are expected to deal with their past abuse when, in fact, they have too many other problems going on in their life at the moment for this to be appropriate.

- The survivor may have strong feelings about who supports them: they may have preferences about a male or female staff member, someone who shares their cultural background (or not), a mental health professional or a voluntary agency."

Slide 42



"Telling someone about what happened can bring up a lot of feelings – even when not a lot has actually been said. Check out what support systems the client has, and always carry the phone numbers for any out-of-hours support your trust provides, as well as for the Samaritans and any local voluntary agencies that provide support for survivors.

You need to check out that the client is currently safe from abuse; they may be current victims of domestic abuse e.g. their partner or carer. If not, consider how they can protect themselves and whether there is a 'safeguarding vulnerable adults' issue here, particularly in the case of older service users or those with learning difficulties.

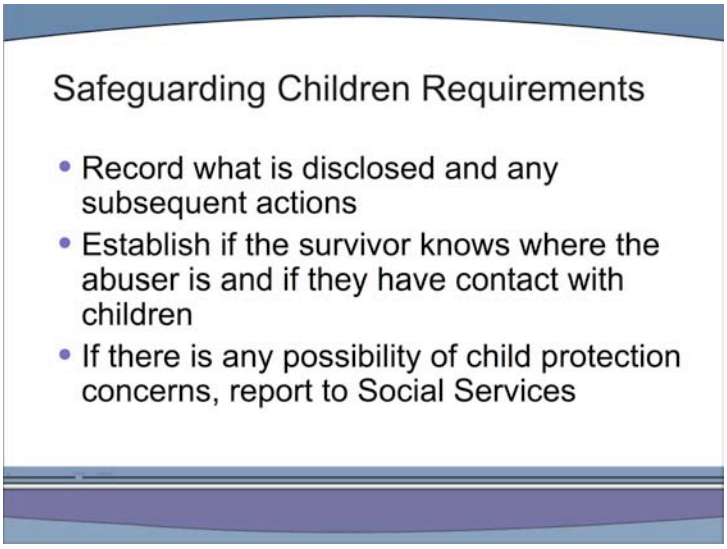
Don't discount the potential for professional abuse; as you know, this can and does happen."

Trainers should familiarise themselves with their own trust's complaints and whistle-blowing procedures, in order to address any questions relating to disclosures of abuse perpetrated by mental health professionals.

"If the abuser is in contact with children and they give you the details, then there is a child protection issue to be raised. This is a professional, legal responsibility and it should not be left to the service user to make the referral.

There are also procedures for reporting concerns about someone who works with children in a professional or voluntary capacity. If you get a disclosure that indicates that the abuser is in this position, then you need to report it to the Social Services Safeguarding Lead."

Slide 43



- **Trainers should be familiar with their local Safeguarding Children and Adults Procedures and have copies available in the room.**
- **Your Safeguarding Leads should be aware of this training and their names and contact details should be included on the blank slide (no. 57): Local support for staff.**

"Now we're going to focus in more detail on Safeguarding Children.

Our local Safeguarding Children's Board has a Procedures Manual providing guidelines on the required response of staff dealing with disclosures of historical abuse. In brief, they require you to do what is said on the slide.

As soon as it is apparent that an adult is revealing child abuse, you must record what is said by the service user and any subsequent action you take.

It is important to record accurately what is said. Written records need to include:

1. Brief details of the abuse as disclosed by the service user and any subsequent action taken
2. Who the service user has previously disclosed to
3. The date and the staff member's legible signature or name

Always take notes that use reported speech: 'Matthew said his uncle was a sadist' or put it in quotation marks: Matthew said, "My uncle was a sadist" and not 'Matthew's uncle was a sadist'.

If possible, you should establish if the adult is aware of the alleged perpetrator's whereabouts and contact with children.

If the services user's responses indicate any possibility that a child may be at risk, then it has to be reported to Social Services. You have a responsibility to ensure this happens. The service user may want to be involved in reporting it themselves and they should be supported to do so if they wish but, if they don't, you need to report it anyway.

Social Services will conduct their investigation and involve the police in the current child protection concern. They will ask the service user whether they want to report their own abuse to the police and reassure them that the police are able and willing to undertake such work, even for those adults who are vulnerable as result of their mental health or learning difficulties, or who are worried that they won't be taken seriously.

If the survivor wants to make a police statement, you should inform them of the process. Police forces have specialist Child Abuse Investigation Units experienced in dealing with child protection issues. If there is no identified child at risk, historical abuse in smaller forces is dealt with by the CID, who will liaise with the child protection department if necessary.

It would be useful to clarify the process in your local police force, if you are able to.

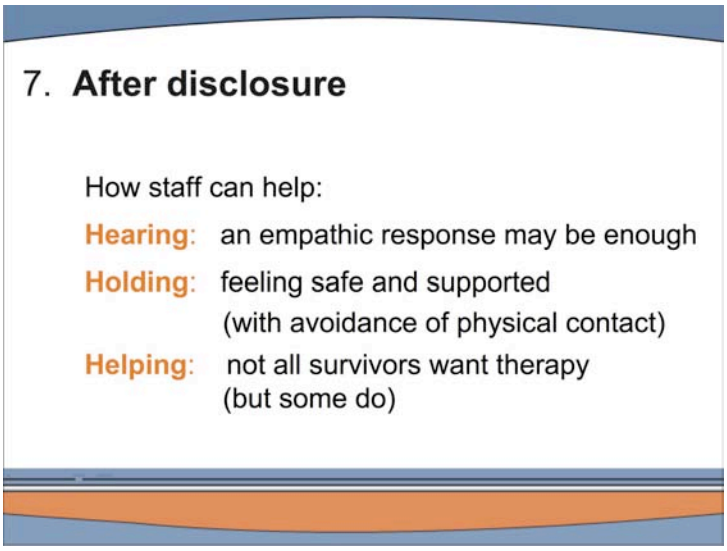
The police acknowledge that effective investigation and successful prosecution is hampered by the passage of time. Crucial evidence may no longer be available and an absence of corroboration may be a significant hurdle to prosecution. However, they emphasise that information given could support the allegations of others or enable another enquiry to proceed.

Remember, it is not necessary for a service user to make a police complaint about their own past abuse in order to protect children – a child protection concern can be raised with Social Services quite separately. A written account of the events/ concerns may be necessary, but this is not the same as making a police statement.

If unsure, before undertaking any of the above you may wish to seek advice from your team leader/ward manager and, if necessary, the Safeguarding Lead in the trust. It's worth bearing in mind that routine enquiry of abuse – in addition to improving the care we provide to survivors of abuse – has a significant role to play in protecting a greater number of children and identifying more abusers. "

Section 7: After disclosure

Slide 44: Time – 4.30 pm



"All therapeutic work with survivors aims to reduce isolation, shame and self-blame and to increase self-worth, personal strength and competence. In the longer term, such changes impact, for example, upon depression, self-harm and substance abuse. Coping strategies are likely to be the last to change as these are what have helped survivors get by for so long, and they will continue to be needed until other changes are firmly established.

Not all survivors will want therapy. Some may regard their abuse as less significant – in their lives – than other issues. Never underestimate the helpful impact you can have by just listening and responding supportively. This may be all they want/need initially. The most important thing is to empower survivors to make their own choices and to work at their own pace.

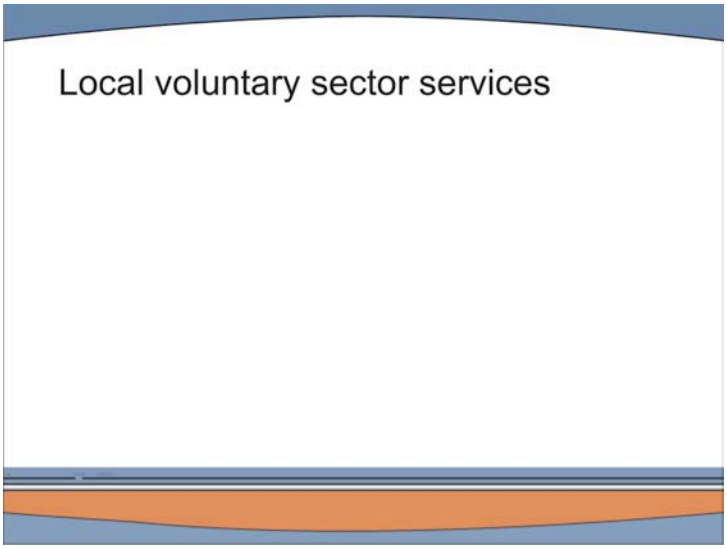
However, many survivors will, at some stage, choose to engage in individual counselling or therapy; some will undertake therapeutic group work. Any therapy

that focuses on their abuse will churn up painful memories and feelings, and they will be better able to cope with some supported preparation."

Slide 45

"Support for survivors operates at many different levels. Remember that long-term therapy and specialist support are required only by some. Mental health practitioners have important roles to play in provision at each of these levels."

Slide 46

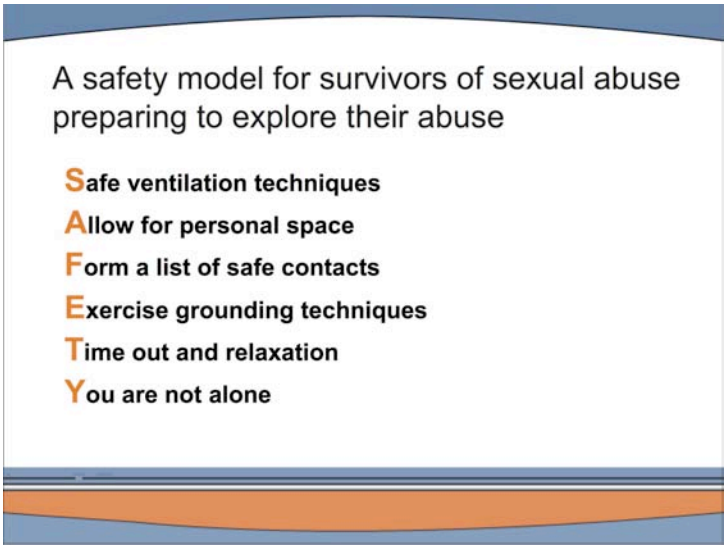


This slide has been left blank for you to insert information and contact details for any specialist services provided by voluntary sector agencies. You may want to invite participants to:

- **say what services they know are available in their patch, in case survivors want to use them;**

- **reiterate the importance of knowing about local, quality services to facilitate survivor choice, and not to just refer clients on to the voluntary sector.**

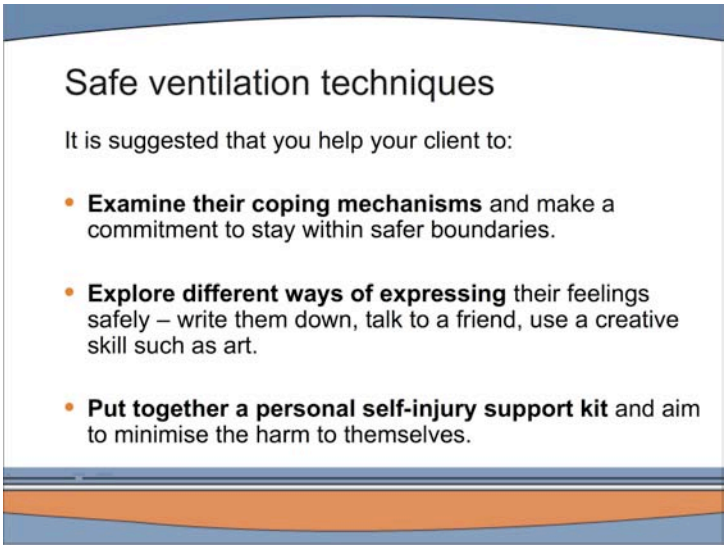
Slide 47

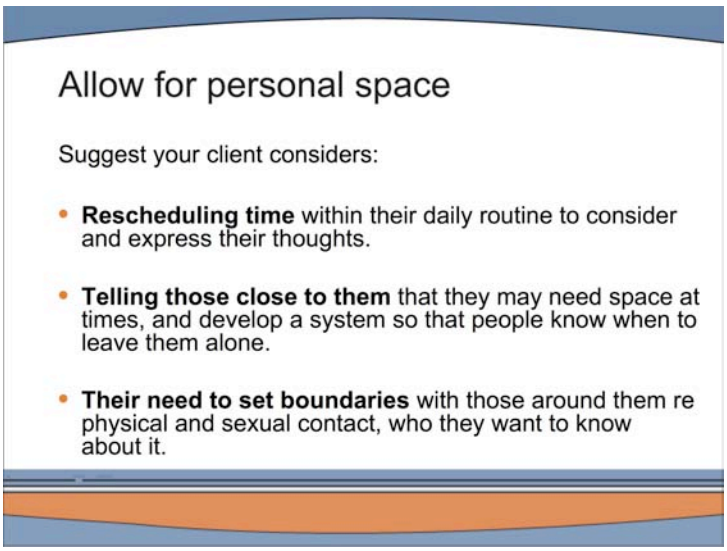


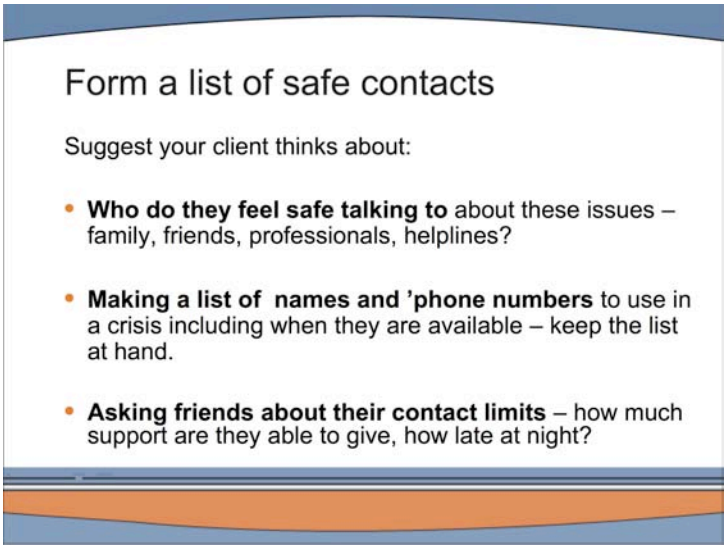
"This Safety Model was designed to help survivors get ready for participation in a survivors' group. It aims to increase an individual's confidence and competence in looking after their day-to-day well-being during stressful periods. You will find it can be equally helpful for survivors who are not currently contemplating therapy, but who still need some positive coping strategies to deal with their distress.

Anyone who is supporting a survivor can introduce them to this model and work through it with them over a series of meetings or key worker sessions. It is intended to be an empowering model which works at the survivor's own pace, encouraging them to take responsibility for their own therapeutic process and self-care. It can work well in conjunction with working through the exercises in 'Breaking Free', as well as being useful for those preparing for a group or one-to-one therapy. You'll find a copy of the Safety Model in your Course Reader."

Slides 48-53
No notes







Exercise Grounding Techniques

Help your client learn about safe grounding techniques by:

- **Identifying a place** where they feel safe to go if they're experiencing flashbacks, memories
- **Reminding themselves** of where they are, look at the things around them, staying in the present
- **Writing down their experience** as soon as they feel able to, or discussing it with someone
- **Identifying a safe grounding object** – a piece of jewellery, a soft toy, a key ring, something they can keep at hand.

Time out and relaxation

Encourage your client to take time out and relax, so help them think about how they can do this:

- **Exploring several activities** that they can use to take time out from their abuse
- **Scheduling daily time** in their routine to take time out and relax – they deserve this
- **Trying out new hobbies** / rediscovering old ones
- **Considering their coping mechanisms** and make a list of those that help them to relax safely

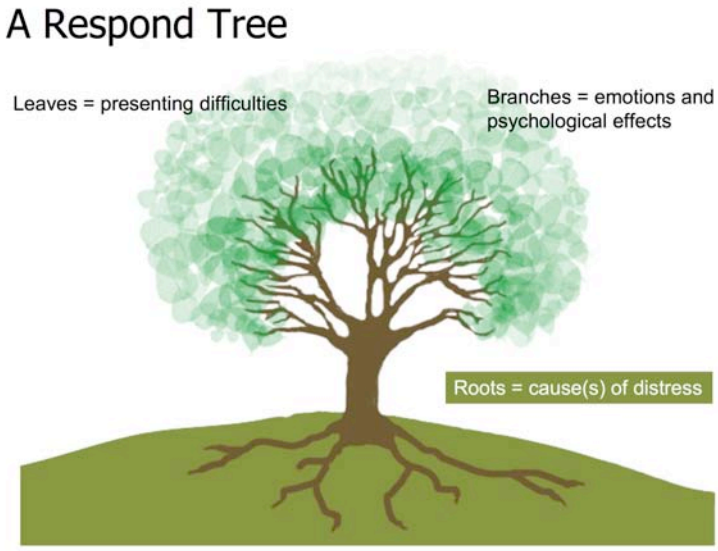
This is good advice for you as a practitioner too!

You are not alone…

Help your client to realise that:

- **Others have been at the stage they are in** at the moment, and survived.
- **Things will get better** for them with time, patience and support.
- **Joining a support group** will help them to see how others are coping, and to share their frustrations with those who understand what they're going through.

Slide 54

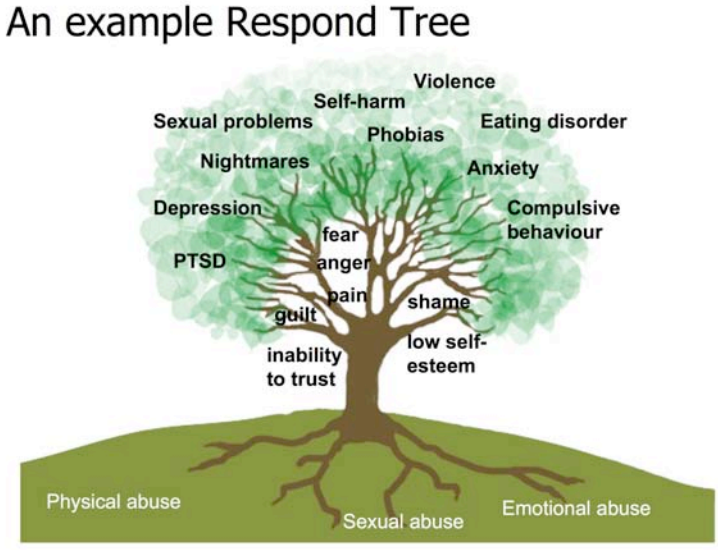


If you have a tool you prefer for direct work with survivors, you may want to insert it here in place of the Respond Tree.

"Survivors often want to make sense of the role of their abuse in their current difficulties. This tree was designed by Respond* (an organisation specifically supporting people with learning difficulties who are affected by trauma or abuse) as a visual aid to help answer the question: *"Why has it affected me like this?"* You may find it a useful tool, to help people you work with, in making sense of the effects of abuse on their lives.

**Respond has an excellent website: www.respond.org.uk*

Slide 55



"A personal tree can be completed with a survivor to help them think about the relationship between their abuse, its impact on them and the difficulties they now have."

Slide 56

"In order to support service users appropriately, staff themselves need to be well supported. Hearing about the violence and abuse in people's lives and acknowledging its impact takes its toll on staff too. To avoid being overwhelmed – and to be enabled to work in an open, empowering way – requires having access to four different kinds of support:

- First up is the ***informal support*** of colleagues including regular discussion of cases and opportunities for 'off-loading' after a difficult session.

Give an example from your own experience.

- Second is ***formal clinical supervision*** which should be regular and quite distinct from line-management meetings. Whether in a group or one-to-one, clinical supervision is the opportunity for you to reflect on relationships with clients, including your own feelings and practice.

Mention here your trust's supervision policy.

- Third is access to ***specific expertise*** in abuse. Trauma and abuse are areas that some practitioners have developed particular expertise in and are able to provide case consultancy to others.

Contact details for identified practitioners will hopefully be included on the blank slide (no. 57): Local support for staff

- Fourth is the need for ***continuing professional development*** which can take many forms both in-house and externally.

Cite here any internal clinical seminars, courses and/or details of your Sexual Abuse Practice Development Forum (if available). In addition, any continuing professional development courses available at local universities.

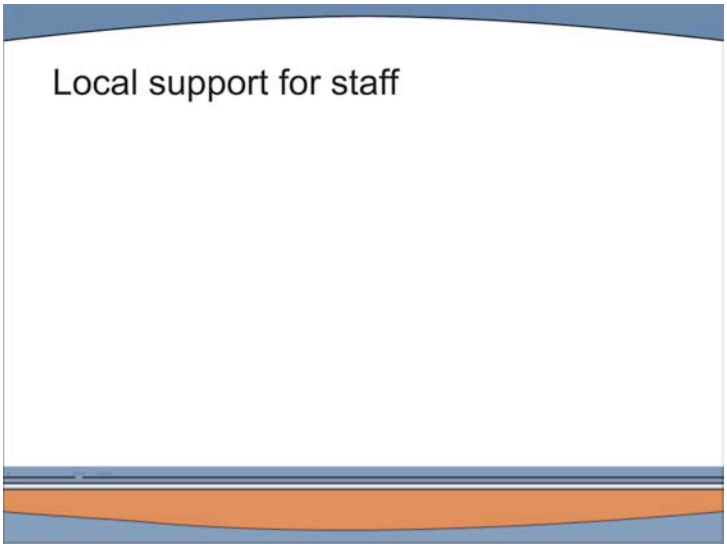
Your own reading will play a big part in your professional development. It can be hard to find time to locate and read academic articles, but the Course Reader provides accessible summaries of the evidence-base for this training.

It includes a short reading list of recommended books, including autobiographical accounts by survivors, which can give you valuable insight into the struggles and coping strategies of some of your clients. A copy of the course PowerPoint is also included as a useful revision tool.

Reading 'Breaking Free' and looking through the accompanying workbook for survivors will increase your confidence in providing a thoughtful, helpful response to disclosures of sexual abuse."

Make sure copies of both are available for people to look through, and hopefully confirm that your trust has ensured/will ensure that every team – that receives the training – has a copy of each publication.

Slide 57



This slide has been left blank for you to insert appropriate local information and contact details for the following, if available:

- **Confidential staff counselling service**
- **Practitioners who can provide specific supervision/case consultation on sexual abuse**
- **Contact details for Safeguarding Leads (Children & Adults)**

Section 7: Debriefing

Slide 58: Time – 4.45 (latest)

You may like to end the day by asking participants to each name one thing they will take away from the day. Whilst they are still seated, hand out evaluation forms to be completed before leaving, using the specially designed form in your Trainers' Manual. (And don't forget to hand out attendance certificates.)

Congratulations – you've survived to train another day!

DH Department of Health

National Institute for Mental Health in England